

**BACKUP AGREEMENT**

PROVIDER'S NAME (*First, Middle, Last*)

I shall use my backup only for the situations listed below:

- When I am ill;
- When I am attending to an emergency related to the provision of child care;
- When I have an emergency involving me or my dependent family members;
- When I need to attend a non-emergency appointment for myself or a dependent family member, and I cannot schedule the appointment outside of normal child care hours;
- When I am attending classes to meet training requirements; or
- When I am taking a vacation.

I understand that backup child care must be conducted in a licensed or certified child care facility and that it is my responsibility to compensate my backup.

At the time of enrollment, I shall inform the parents or guardians of children of my backup arrangements so that they may make other arrangements, if they desire, and I shall provide the parents or guardians of children receiving DES certified child care with a copy of this agreement.

I shall inform my Child Care Certification Specialist and Parents/Guardians within 24 hours if I need to use my backup.

I shall inform my Child Care Certification Specialist and Parents/Guardians if I need to arrange for a new backup and provide them with a new backup agreement.

I understand that I am responsible for arranging for a competent adult to act as my backup who meets the requirements for backup providers as set forth in R6-5-5202.

In the event an emergency arises and my backup provider is unavailable, I shall immediately notify my Child Care Specialist of the emergency and obtain pre-approval for the use of a substitute backup provider acceptable to the department.

SIGNATURE OF CHILD CARE PROVIDER	DATE
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**BELOW SECTION TO BE COMPLETED BY THE BACKUP PROVIDER**

BACKUP PROVIDER'S NAME (*First, Middle, Last*) OR CHILD CARE FACILITY NAME

ADDRESS (*No., Street, City, State, ZIP*)

AREA CODE AND PHONE NO. (       )	AVAILABLE HOURS
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**Please check one box and sign and date the appropriate line below.**

Department of Health Services (DHS) Licensed Child Care Center  
  DHS Certified Group Homes  
  DES Certified Provider  
 I am aware that my child care facility provides backup service to the above mentioned provider.

SIGNATURE OF CHILD CARE FACILITY DIRECTOR OR OWNER	DATE
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Individual Back-up Provider  
 I am age 18 or older, and understand the specific guidelines regarding my duties as outlined above. I understand that I must furnish proof of my immunization record and complete initial and annual TB tests. I am aware that I am subject to a Child Protective Services (CPS) clearance check and fingerprinting for a criminal background investigation. I am aware that my ability to provide backup child care is contingent on clearance through CPS Clearance check. I understand that I must maintain current CPR/First Aid Certification to provide back up services for the above mentioned provider.

SIGNATURE OF BACKUP PROVIDER	DATE
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Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact 602-542-4248; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. • Disponible en español en la oficina local.