Western Oregon UNIVERSITY
The Research Institute

[LE-21] Safety & Quality Enhancement Reimbursement Form

For License Exempt Family Child Care Providers Participating in ODHS Subsidy

Who is eligible? License exempt Family Child Care Providers participating in ODHS Subsidy.

What is reimbursable? The reimbursement will be available for the cost of equipment, or facility repairs that were directly paid by the program and have not been paid by a third party to help comply with ODHS health and safety requirements. The reimbursement shall not exceed two hundred and fifty dollars ($250.00) per year. Smoke detectors and outlet plugs may be available through the Oregon Department of Human Services (ODHS) Direct Pay Unit (DPU) at 1-800-699-9074 or the Office of Child Care at 1-800-556-6616.

Requirements for reimbursement:

1. Original Receipt/s showing payment.
2. WOU Substitute W-9.

Do you provide child care to infants or toddlers (ages 0-3)? ☐ **Yes** ☐ **No**

Provider Name _____ Date _____

DHS Provider ID _____ ( ) Phone # _____

Date of Purchase	Type of equipment, or repair	Cost per item	What need does this item/service meet?	For office use only: Approval (Y/N)

Attach additional pages if needed

How did you learn about this reimbursement?
☐ Local CCR&R ☐ DHS Listing Form ☐ Licensing Specialist ☐ Other:_____

Payment Information: (Must match WOU Substitute W-9.)

Name of business/individual requesting reimbursement _____ Street Address _____

City _____ State _____ Zip _____

Signature _____ Date _____

By signing I hereby affirm that the above information is true and accurate and that the costs were paid directly by myself/ program and have not been paid by a third party.

Include the following with this form:

1. **Original Receipt/s**
2. **WOU Substitute W-9**

Note: Forms with missing information will be held for payment until information is received.

Mail forms to:
Western Oregon University
TRI/Central Coordination of CCR&R
345 N Monmouth Ave
Monmouth, OR 97361

Questions: 503-838-8008, tripayments@wou.edu

For Business Use Only
Amount:
Invoice #:
Index #:
Account Code:
Approved by:
Not to exceed $250 p/year

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Demographic Questionnaire

You may choose not to provide demographic information. It will not affect the status of your reimbursement/stipend.
Note: For First Aid/CPR Reimbursement for Aide 1/Assistant 1 please have the Aide 1/Assistant 1 complete the Questionnaire.

Program/Provider Name _____ Date _____

Program License # _____ ( ) Phone # _____

☐ **Decline to answer questionnaire**

1. Which of the following describes your racial or ethnic identity? Please check All that apply.

☐	Native American	☐	Native Hawaiian or Pacific Islander
	☐American Indian ☐Alaska Native ☐Canadian Inuit, Metis ☐Indigenous Mexican ☐Central American ☐South American ☐Other Native American (please list) _____		☐Guamanian or Chamorro ☐Micronesian ☐Native Hawaiian ☐Samoan ☐Tongan ☐Other Pacific Islander (please list) _____
☐	Hispanic of Latinx	☐	Black or African American
	☐Hispanic or Latinx - Central American ☐Hispanic or Latinx - Mexican ☐Hispanic or Latinx - South American ☐Other Hispanic or Latinx (please list) _____		☐African American ☐African (Black) ☐Caribbean (Black) ☐Other Black (please list) _____
☐	Asian	☐	Middle Eastern
	☐Asian Indian ☐Chinese ☐Filipino/a ☐Hmong ☐Japanese ☐Korean ☐Laotian ☐South Asian ☐Vietnamese ☐Other Asian (please list) _____		☐Northern African ☐Middle Eastern ☐Other (please list) _____
		☐	White
			☐Eastern European ☐Slavic ☐Western European ☐Other White (please list) _____

2. What is your preferred language? List below.

_____