

Exhibit 3: Provider Reimbursement Rates

Provider Name: _____

Provider Operational Hours: _____

PROVIDER must mark the appropriate box below indicating the appropriate provider type. In addition, PROVIDER must mark whether or not it has a Gold Seal Quality Care Designation. Finally, PROVIDER must complete the table below marked "To be completed by PROVIDER." COALITION will complete the remainder of the Exhibit.

Does PROVIDER have a Gold Seal Designation? Yes No

PROVIDER's Private Pay Rates
(To be Completed by PROVIDER)

CARE LEVEL	(INF) <12 MTH	(TOD) 12<24 MTH	(2YR) 24<36 MTH	(PR3) 36<48 MTH	(PR4) 48<60 MTH	(PR5) 60<72 MTH	(SCH) In School	(SPCR) Special Needs If applicable
Full-Time Daily Rates								
Part-Time Daily Rates								
Before or After School Rates	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

COALITION Maximum Reimbursement Rates
(To be Completed by COALITION)

CARE LEVEL	(INF) <12 MTH	(TOD) 12<24 MTH	(2YR) 24<36 MTH	(PR3) 36<48 MTH	(PR4) 48<60 MTH	(PR5) 60<72 MTH	(SCH) In School	(SPCR) Special Needs
Full-Time Daily Rates								
Full-Time Gold Seal Daily Rates								
Part-Time Daily Rates								
Part-Time Gold Seal Daily Rates								
Before or After School Rates	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Full-Time VPK Wrap Rate	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Part-Time VPK Wrap Rate	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Approved PROVIDER Reimbursement Rate*
(To be Completed by COALITION)

CARE LEVEL	(INF) <12 MTH	(TOD) 12<24 MTH	(2YR) 24<36 MTH	(PR3) 36<48 MTH	(PR4) 48<60 MTH	(PR5) 60<72 MTH	(SCH) In School	(SPCR) Special Needs If applicable
Full-Time Daily Rates								
Part-Time Daily Rates								
Before or After School Rates	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Full-Time VPK Wrap Rate	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Part-Time VPK Wrap Rate	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

**Note: Rate PROVIDER will be paid shall not exceed PROVIDER's Private Pay Rates for each category.*

Effective Date of Rates Established in This Exhibit _____