State of Illinois
Department of Early Childhood

CHILD CARE PROVIDER PAID LEAVE REQUEST FORM

CCAP Provider ID#: _____ County: _____

Provider Last Name: _____ First: _____ Date of Birth: _____

Business Name (if applicable): _____

Date(s) of Requested Leave

_____ _____ _____ _____ _____

INSTRUCTIONS

- Paid leave days are available for home child care providers who have received a CCAP payment within the previous fiscal year (July-June).
- Effective July 1, 2025, providers shall receive three (3) days of paid leave to be used between July 1, 2025-June 30, 2026, if they received any CCAP reimbursement, for care provided for a CCAP child, during the prior fiscal year (July 1, 2024-June 30th, 2025.
- Effective July 1, 2026, providers shall receive five (5) days of paid leave to be used between July 1, 2026-June 30, 2027, if they received any CCAP reimbursement, for care provided for a CCAP child, during the prior fiscal year (July 1, 2025-June 30, 2026.
- Providers MUST complete, sign and submit this form to the CCR&R no later than with the billing certificate for the month in which day off occurred.
- Leave requests for months that have already been paid for will only be paid and deducted from the annual total if the provider had not already been paid for the day through the 70% Attendance Percentage policy.
- Paid leaves shall be used only in full-day increments by the provider and may be used for any purpose.
- Leaves shall be paid at the full-time rate, regardless of the rate type the child is approved.

INDIVIDUAL PROVIDER / CUSTOMER CERTIFICATION

I certify that the above requested days are in accordance with the Child Care Assistance Program rules and policies related to Paid Leaves and, - as described in Article VIII of the SEIU Collective Bargaining Agreement, effective July 1, 2023 through June 30, 2027. I further certify to the best of my knowledge and belief that I have sufficient Paid Leave days to cover the dates specified in this request. I understand that if I have insufficient days to cover the full length of the request or if the requested day(s) has already been paid for, the request may be rejected and/or returned to me for correction. I understand falsification of any information submitted could lead to a rejection of my paid time off. I have notified my customer regarding care for these days.

Provider Signature: _____ Date: _____