



# How to Register as an Approved Relative Provider

Child Care Assistance Provider

# Before getting started:



Be prepared to fully finish the registration process as the system will not save your place. This should take about 10 minutes.



Documents needed:

- W9
- SFN 23
- SFN 433
- Verification of relationship to the children care will be provided for
- Verification of SSN or EIN

- Go to <https://dhsprovider.dhs.nd.gov/>.
- Under CCAP Providers, click "Sign In."

**Self-Service Portal (SSP) for Providers and Vendors**  
Welcome to the Department of Human Services Online Self-Service Portal

Register as a Child Care Assistance Program (CCAP) provider, a Low Income Home Energy Assistance Program (LIHEAP) Vendor, or register for an HPE provider account and submit HPE applications.

**CCAP Providers**  
View provider information about CCAP [here](#).  
For provider licensing information click [here](#).  
**Sign In**

**LIHEAP Vendor**  
Find information on becoming a LIHEAP Vendor [here](#).  
**Sign In**

**Hospital Presumptive Eligibility**  
Refer to the HPE Desk Reference Manual provided at [training](#).  
**Sign In**

**For Client Portal** [click here](#)

- Enter the login credentials for your North Dakota login account.

North Dakota  
login

## Sign in

Don't have a North Dakota Login?  
[Create an account.](#)

User ID

[Forgot user ID?](#)

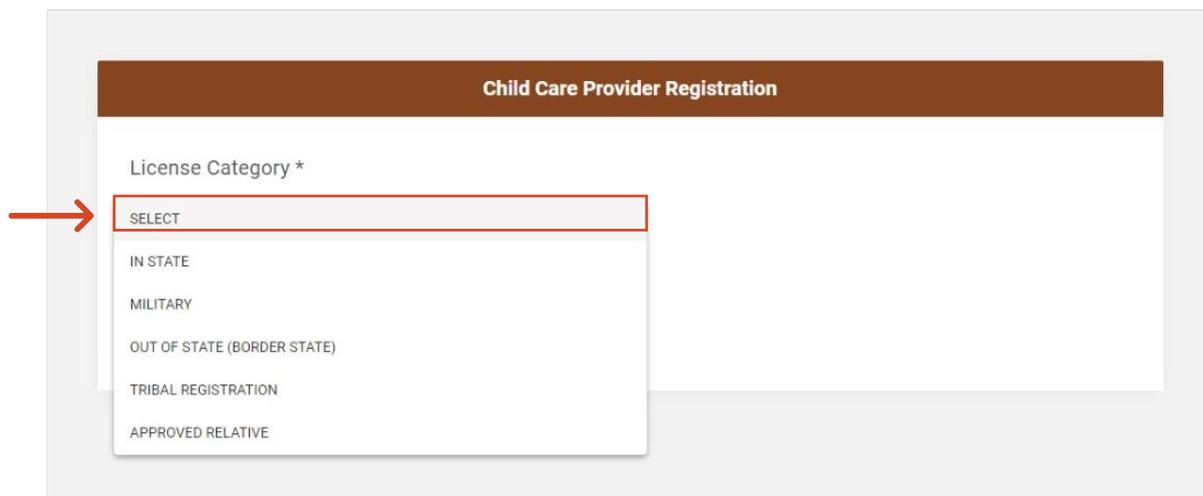
Password

[Forgot password?](#)

Sign In

- Click the drop-down box and select the license category that applies to you.

- Once you've selected your license type, enter your Provider Tax Identification Number.
- Click verify.



Child Care Provider Registration

License Category \*

SELECT

IN STATE

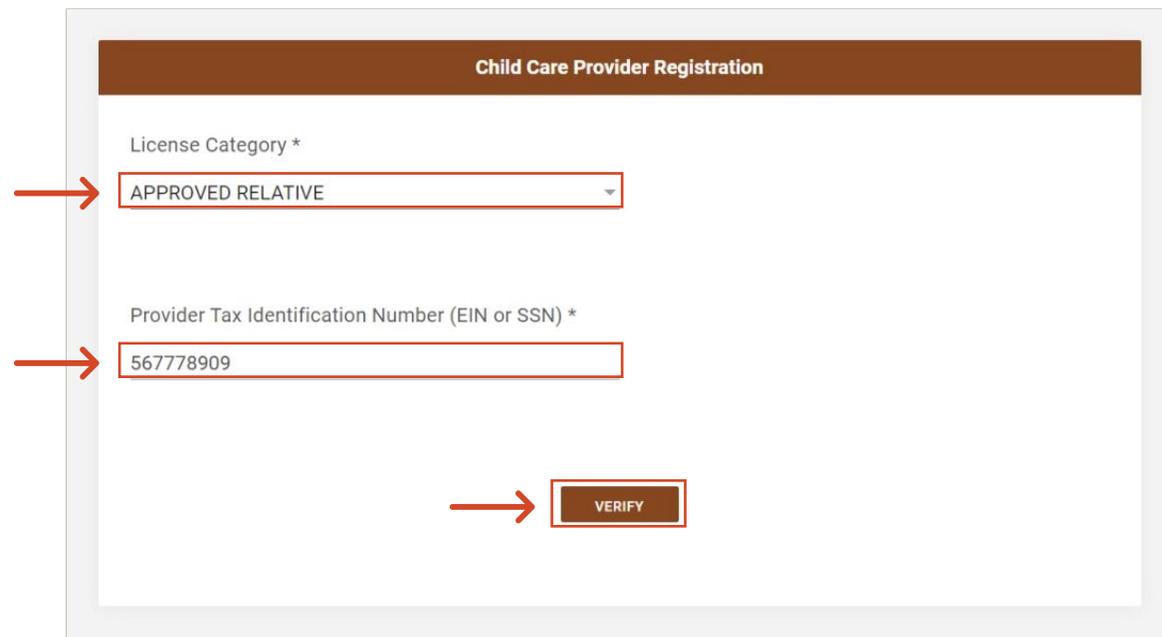
MILITARY

OUT OF STATE (BORDER STATE)

TRIBAL REGISTRATION

APPROVED RELATIVE

This screenshot shows the 'Child Care Provider Registration' form with the 'License Category \*' dropdown menu open. A red arrow points to the 'SELECT' option, which is highlighted in a light gray box. Other options listed include 'IN STATE', 'MILITARY', 'OUT OF STATE (BORDER STATE)', 'TRIBAL REGISTRATION', and 'APPROVED RELATIVE'.



Child Care Provider Registration

License Category \*

APPROVED RELATIVE

Provider Tax Identification Number (EIN or SSN) \*

567778909

VERIFY

This screenshot shows the 'Child Care Provider Registration' form with the 'License Category \*' dropdown menu set to 'APPROVED RELATIVE'. A red arrow points to the dropdown box. Below it, the 'Provider Tax Identification Number (EIN or SSN) \*' field contains the number '567778909', with a red arrow pointing to the input box. At the bottom right, the 'VERIFY' button is highlighted with a red arrow.

- If you are known to SPACES you will see this message.
- Enter your SPACES ID then click "Link account."
  - Note: this is at the bottom of notices you receive.

### Child Care Provider Registration

You are already known to SPACES. If you want to associate your Provider Account, please enter your Provider ID and click 'Link Account' button. Or if you want to enroll yourself as a new Provider, please click 'Register' button.

If unsure, please click 'Cancel' button and contact Child Care Assistance Policy for any further queries.

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- As an Approved Relative Provider you will need to upload the documents listed in the “Approved Relatives” column below.
- Click on hyperlinks if you need a copy of the SFN 23 or SFN 433.
- Click “Provider Registration & Verification” to continue.

Provider Registration/Association & Verification

Certain documents will be required for registration:

In State Providers	Out of State / Tribal / Military Providers	Approved Relatives
<ul style="list-style-type: none"> <li>W9</li> </ul>	<ul style="list-style-type: none"> <li>W9</li> <li>Copy of current license</li> </ul>	<ul style="list-style-type: none"> <li>W9</li> <li><a href="#">SFN 23 - Approved Relative Application</a></li> <li><a href="#">SFN 433 - Child Abuse and Neglect Background Inquiry</a> (for all household members over the age of 18)</li> <li>Verification of relationship to the children that care will be provided for (birth certificates, adoption papers, court records)</li> <li>Verification of SSN or EIN</li> </ul>

A provider agreement must be completed in order to request and receive payment from the Child Care Assistance Program.

Click on the 'Provider Registration & Verification' button to complete registration:

Provider Registration & Verification

- Verify the information shown. If changes are needed you can make them.
- If you would like payment to go to the family, check the “Pay to Family” box.
- Click “Next.”

NORTH  
**Dakota** Be Legendary.  
Health & Human Services

My Account  

### Child Care Provider Details

Business Name  
\_\_\_\_\_

First Name  
Jane  
\_\_\_\_\_

Middle Initial  
\_\_\_\_\_

Last Name  
Smith  
\_\_\_\_\_

Provider License Number  
\_\_\_\_\_

Provider License Start Date  
4/1/2022 

Provider License Expiration Date  
3/31/2023 

- Verify the information shown is correct, then click "Next."
- If changes are needed you may edit the details.

NORTH  
**Dakota** Be Legendary.  
Health & Human Services

My Account ▼ 

### License Address Details

Residence Address

Street Address \*  
2112 3rd St

Address Line 2

City \*  
Bismarck

State \*  
NORTH DAKOTA ▼

Zip Code \*  
58503

Phone Number \*  
(701) 112-2111

Email Address

Is your mailing address the same as street address? \*

Yes  No

- Enter your banking information to enroll for direct deposit.
- If your info is already on file, it will be populated. If you would like to verify the details, click the boxes with \*\*\* to display the information.

- If you would like to apply for a direct deposit exemption, click the box for a dropdown menu.

### Direct Deposit Details

Name of Bank \*  
Bank Name

Bank Account Number \*  
\*\*\*\*\*5654

Confirm Account Number \*  
\*\*\*\*\*5654

Bank Routing Number \*  
\*\*\*\*0909

Type of account? \*  
CHECKING ACCOUNT

If you'd like to apply for direct deposit exemption please select one of the following reasons. Note: You must provide proof of reasoning. Please upload your proof on the Upload Documents Screen.

SELECT

BACK NEXT

If you'd like to apply for direct deposit exemption please select one of the following reasons. Note: You must provide proof of reasoning. Please upload your proof on the Upload Documents Screen.

SELECT

UNABLE TO OBTAIN A BANK ACCOUNT

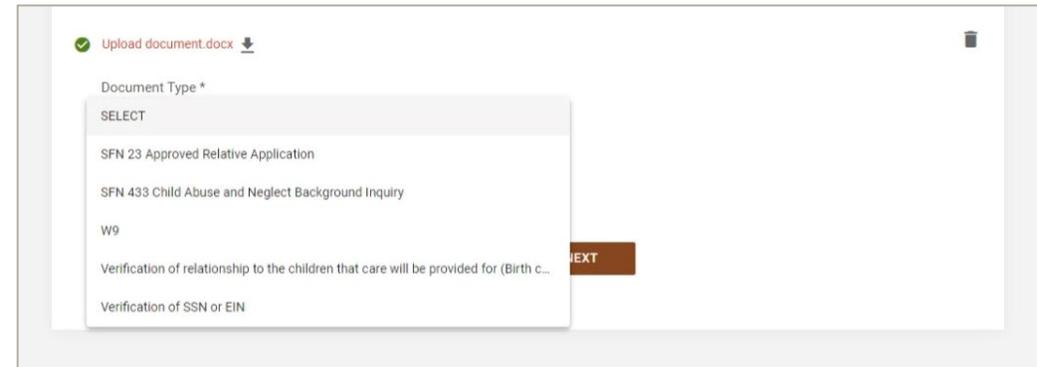
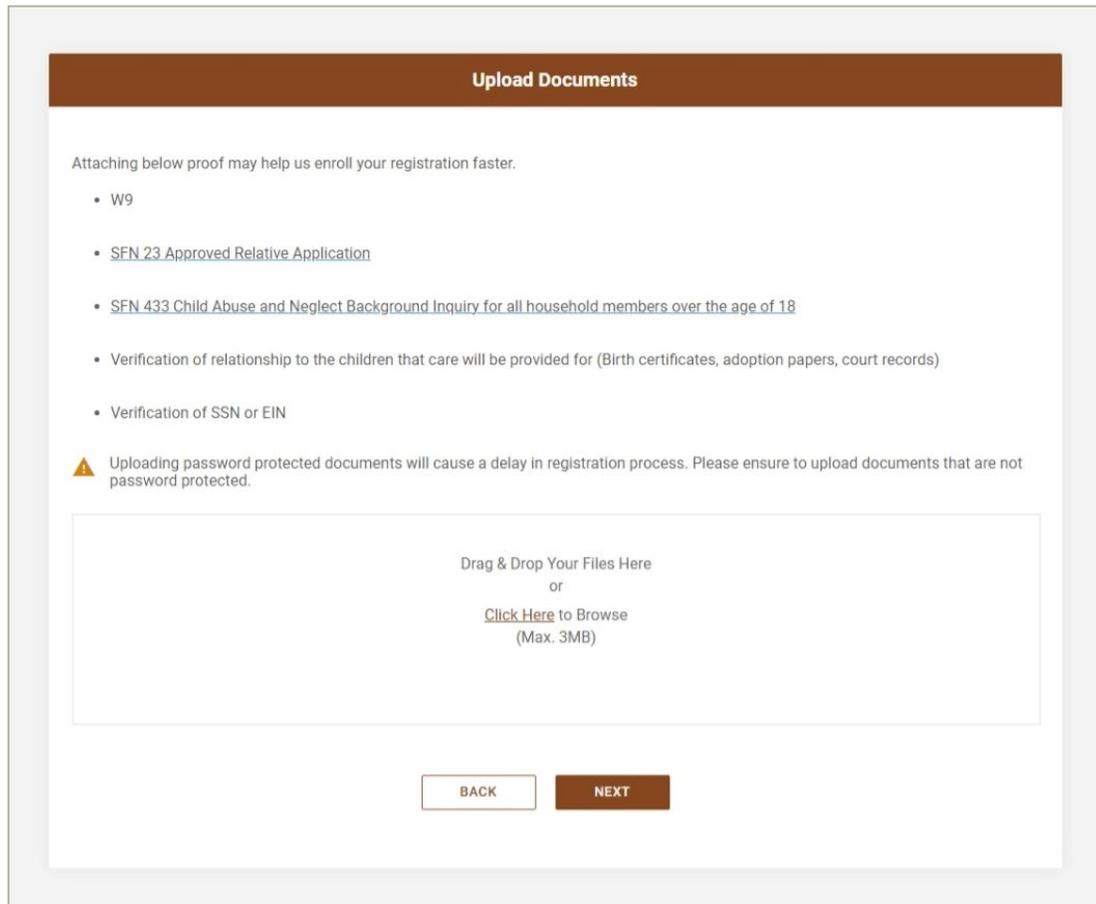
BANKRUPTCY

OTHER

BACK NEXT

- Upload the required documentation.

- Use the dropdown to select the doc type for each upload.
- Click “Next” when you have finished uploading documents.



- Enter the details as listed on your W9.
- If information is already listed, verify or edit.

The screenshot shows a web portal for North Dakota Health & Human Services. The top navigation bar includes 'Dashboard', 'My Associations', 'View Statements & Documents', and 'FAQ'. The user is logged in as 'My Account'. The main content area is titled 'W9 Details' and contains the following form fields:

- Taxpayer Identification Number (TIN)**: Radio buttons for 'SSN' and 'EIN'.
- Name (as shown on your income tax return) \***: Text input field.
- Is payment address same as \***: Dropdown menu with 'SELECT' as the current selection.
- Payment Address**: Section header for the address fields.
- Street Address \***: Text input field.
- Address Line 2**: Text input field.
- City \***: Text input field.
- State \***: Dropdown menu with 'SELECT' as the current selection.
- Zip Code \***: Text input field.

Below the form fields, there is a note: 'Please upload a signed copy of your W9 form on the next screen'. At the bottom, there are two buttons: 'BACK' and 'NEXT'.

- Read through the provider agreement.
- Click the “I have read and agree” box, then click next to finish the registration process.
- If you would like a copy of the provider agreement, click here.

**North Dakota** Be Legendary.  
Health & Human Services

My Account

Dashboard My Associations View Statements & Documents FAQ

### Provider Agreement

By clicking this box, I certify that the information I provide during the North Dakota Child Care Assistance Program (CCAP) enrollment process is true and correct to the best of my knowledge and that I will comply with all terms, conditions, and responsibilities of this agreement. I understand that I am providing this information so that state agency officials can verify that I am eligible to receive subsidized child care assistance payments.

This Agreement is between the North Dakota Department of Health and Human Services (NDDHHS) CCAP and the provider of child care to children authorized under this Agreement. The Provider agrees to comply with this Agreement and all applicable state statutes, North Dakota Administrative Code (NDAC), and all applicable Federal statutes and regulations in order to be paid for providing child care.

In order to receive Child Care Assistance Payments from the North Dakota Department of Health and Human Services (NDDHHS), I understand and agree to the following:

#### General Information

1. I understand that I must at all times comply with all North Dakota child care laws and rules that apply to the child care I provide, including all rules related to North Dakota CCAP. I understand that failure to comply with North Dakota Child Care Requirements may result in termination of this Agreement.
2. I understand that I must keep all information I receive about children and families confidential.
3. I agree to submit a W-9 Form through the Provider Self Service Portal at initial enrollment with CCAP, to submit an updated form when a change needs to be reported, and periodically review and certify the information is correct.
4. I understand that the income I receive as child care subsidy payments is taxable and all subsidy payments will be reported as income to the Internal Revenue Service. DHHS does not withhold any taxes from subsidy payments.
5. I am responsible for any and all information provided through the Provider SSP. If I allow Financial or Facility Administrative security access to the Provider SSP to anyone else, I will be responsible for any incorrect information provided by that other individual even if the error was unintentional.

- You will see a confirmation that you have successfully completed the registration request process.
- If you are applying to become an Approved Relative Provider, please allow up to 30 days for approval. If already an Approved Relative Provider and are registering for the SSP, please allow up to 2 business days for approval.

The screenshot displays a web interface for North Dakota Health & Human Services. At the top left is the logo with the text "NORTH Dakota Be Legendary. Health & Human Services". At the top right, there is a "My Account" dropdown menu and a notification bell icon, which is highlighted with a red square. Below the header is a dark brown navigation bar containing the text "View Statements & Documents" with a downward arrow. The main content area features a central white box with a dark brown header that reads "Provider Registration/Association & Verification". Inside this box, a green checkmark icon is positioned to the left of a confirmation message: "Your provider registration request has been successfully submitted for review. You will be notified, via the notifications badge in the top right corner of this page, upon final decision or if more information is needed."