



**COLUMBIA COUNTY
DEPARTMENT OF SOCIAL SERVICES
25 RAILROAD AVE., P.O. BOX 458
HUDSON, NEW YORK 12534**

**TELEPHONE (518) 822-0087
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**ROBERT M. GIBSON
COMMISSIONER**

**MICHELLE UBLACKER
DEPUTY COMMISSIONER**

CHILD CARE TIME AND ATTENDANCE USER AGREEMENT

The Provider would like to commence using the New York State Office of Children and Family Services, Child Care Time and Attendance (NYS OCFS CCTA) electronic filing system to submit time records for child care services to Columbia County Department of Social Services electronically.

Upon execution of this agreement, the Provider will electronically submit all claims for payment and all required child attendance information to the County through the use of the NYS OCFS CCTA system.

The Provider acknowledges that they are solely responsible for the information submitted to the County electronically through the NYS OCFS CCTA.

The Provider affirms that such information will be complete and accurate.

The Provider understands and agrees that the County will hold the Provider responsible for any false, incomplete or misleading information submitted to the County by the Provider or under the Provider's name.

The Provider further understands and acknowledges that he/she could be prosecuted under applicable Federal and State laws for any false claims, statements, documents, or payment submitted to the County.

The Provider acknowledges and agrees that any information submitted to the County by Provider's or on Provider's behalf will be treated as if the Provider has personally signed the sheets upon which the information is contained and that the Provider will be held to the same standard as if the submissions were made in written form as opposed to electronic form.

The County reserves the right to rescind this agreement and the Provider's use and access to the NYS OCFS CCTA system. If this agreement is rescinded it will be effective the beginning of the month following the County's notice.

The Provider may terminate this agreement and their use of NYS OCFS CCTA system upon providing the County with at least thirty (30) days written notice. Such termination will be effective the beginning of the month following the notice. This agreement shall remain in full force and effect until terminated pursuant to this paragraph or the program closes.



Program Name: _____ Facility #: _____

Tax ID# _____

Program Address: _____ Phone Number: _____

First Name: _____ Last Name: _____

Role (*circle one*): Director / Primary Provider / Employee/Household Member /Co-Provider / Assistant

Date of Birth: _____ Email: _____

THIS FORM MUST BE SIGNED IN THE PRESENCE OF A NOTARY PUBLIC

I hereby attest that the information provided by me in this certification is true and accurate to the best of my knowledge. I acknowledge that this statement is given under oath.

Signature: _____

Sign in the presence of a notary

Printed Name: _____

Sworn to before me this _____

Day

day of _____

Month

Year

Notary Public – State of New York (affix stamp)