Child Care Inclusion:
Verification of Wages and Benefits Form Guide to Completion

ONLY ONE PAY PERIOD CAN BE SUBMITTED PER FORM

ONLY ONE AUTHORIZATION NUMBER PER VERIFICATION OF WAGES AND BENEFITS FORM

The Child Care Inclusion: Verification of Wages and Benefits form must be completed in full and be consistent with the External Invoice form in order to be processed. Incomplete, inaccurate, and/or inconsistent forms will be returned to the vendor.

Section A: Child Care Service Information

Operating Name:
The name by which the child care service is known, as indicated on the child care licence or approval certificate.

Street Address:
The street address where the child care service is physically located.

City/Town:
The town or city where the child care service is physically located.

Postal Code:
The postal code associated with the physical location of the child care service.

Section B: Vendor Payment Information

Vendor Name:
The name of the corporation to which the funds will be issued. Where a vendor is not incorporated, this should be the name of the individual to which the funds will be issued. **NOTE: This field must be completed even if the vendor address is the same as the child care service operating address.**

Vendor Number:
The number associated with the vendor name. It can be found on the **Authorization to Provide Goods/Services** form**.**

Service Authorization Number:
This number is found on the **Authorization to Provide Goods/Services** form. **The Service Authorization Number for each Support claimed must be entered in this field. A form with a missing or invalid Service Authorization Number(s) will be returned.**

NOTE: Where the vendor address information is the same as the operating address, this can be indicated by selecting ☐ *Same as Operating Address*.

Street Address:
The street address where the vendor receives financial correspondence from the Department. **This address must match the address on the Authorization to Provide Goods/Services form**. This field can

be left blank if the street address is the same as the operating street address and it has been indicated by selecting ☐ ***Same as Operating Address*.**

City/Town:

The town or city where the vendor receives financial correspondence from the Department. **The City/Town must match the city/town on the Authorization to Provide Goods/Services form**. This field can be left blank if the city/town is the same as the operating city/town and it has been indicated by selecting ☐ ***Same as Operating Address*.**

Postal Code:

The postal code associated with the address of the vendor. **The postal code must match the postal code on the Authorization to Provide Goods/Services form**. This field can be left blank if the postal code is the same as the operating postal code and it has been indicated by selecting ☐ ***Same as Operating Address*.**

Section C: Wage Information

Funded Staff Person Name:

The name of the caregiver who provided the inclusion support. This is to be entered as the *Last Name*, *First name*. e.g., Smith, John. **NOTE: The staff name must be consistent with staff identified on the staffing resource sheet found in the Service Agreement and the external invoice form. Substitutes must be identified on the Verification of Wages and Benefits and the External Invoice form. They must also be listed on the Staffing Resource Sheet.**

Pay Period:

From: This is first day of the pay period the service was provided. It is to be entered in YYYY/MM/DD format, e.g., where September 3, 2018 was the first day in the month of September that the service was provided, the information must be entered as 2018/09/03.

To: This is the last day of the pay period the service was provided. It is to be entered in YYYY/MM/DD format, e.g., where September 28, 2018 was the last day in the month of September that the service was provided the information must be entered as 2018/09/28.

NOTE: The Verification of Wages and Benefits form must not contain information with more than one pay period.

Hourly Rate:

The hourly rate of pay for the funded staff person as identified on the paystubs. The amount must be entered in currency format, e.g., $16.45.

Hours Worked:

The total number of hours the funded staff person work during the pay period as identified on the paystubs and employee time sheet. To be entered in number format, e.g., where twenty hours and thirty minutes were worked, it must be entered as 20.50

Hours Worked in Inclusion:
The number of hours the funded staff person worked in the approved support position during the pay period as identified. To be entered in number format, e.g., where twenty hours and thirty minutes were worked, it must be entered as 20.50

Gross Pay:
The number of hours the funded staff person worked in the approved support position during the pay period multiplied by the hourly rate of pay for the funded staff person. The amount must be entered in currency format, e.g., $612.45. **NOTE: When using the electronic fillable version of this form this calculation computes automatically where values have been entered in the applicable fields.**

Vacation Pay (%)
The percentage of the wages of an employee during the year of employment of which the employee is entitled to vacation and has paid to the funded staff person identified. It must be consistent with the vacation pay as identified on the paystub. The percent amount must be entered in number format, e.g., where four percent is the percentage paid to the funded staff person, it must be entered as 4. The vacation pay amount must be entered in currency format, e.g., S103.15. **NOTE: When using the electronic fillable version of this form the percentage in dollar amounts computes automatically where a percentage value has been entered in the applicable field.**

Total
The total amounts of gross pay plus vacation pay claimed for the funded staff person identified. The amount must be entered in currency format, e.g., $612.45. **NOTE: When using the electronic fillable version of this form this calculation computes automatically where values have been entered in the applicable fields.**

Employer's CPP
The amount of Canada Pension Plan paid on behalf of the funded staff person identified. This amount must be calculated using the Government of Canada's Employer's CPP rate based on the gross pay for the inclusion hours worked. The amount must be entered in currency format, e.g., $103.15.

Employer's EI
The amount of Employment Insurance paid on behalf of the funded staff person identified. This amount must be calculated using the Government of Canada's Employer's EI rate based on the gross pay for the inclusion hours worked. The amount must be entered in currency format, e.g., $103.15.

Workers Compensation
The amount of Workers Compensation paid on behalf of the funded staff person identified. The amount must be entered in currency format, e.g., $103.15.

Other[1] (specify benefit below)
The amount of any other benefit paid on behalf of the funded staff person identified. The type of benefit must be identified in the space provided and the amount paid must be entered in currency format, e.g., $103.15. **NOTE: Benefits paid on behalf of the funded staff person must deemed eligible and not exceed 20%.**

Total Claimed:
This is the total amount for all wages and benefits claimed for the pay period identified minus the 80% initial payment deduction (where applicable) for the identified funded staff person. The amount must be entered in currency format, e.g., $725.78. **NOTE: When using the electronic fillable version of this form this calculation computes automatically.**

Licensee/FCC Provider/Authorized Designate (please print):
The printed name of the licensee/FCC Provider or authorized designate who signed the form in the next field. Every effort should be made to ensure the name is legible. **NOTE: the form will be returned where the name is missing from this field.**

Signature:
This is the signature of the individual identified as the licensee, FCC provider or authorized designate. A signature in this area certifies that the information provided in the form and any supporting documentation required is accurate and true. **NOTE: the application will be returned where the original signature is missing.**

Date:
This is the date the form was completed and certified and signed by the licensee/FCC Provider or authorized designate. It is to be entered in YYYY/MM/DD format, e.g., where the date is September 28, 2018, the information must be entered as 2018/09/28.

Funded Staff Person (please print)
The printed name of the caregiver identified as the funded staff person. Every effort should be made to ensure the name is legible. **NOTE: the form will be returned where the name is missing from this field.**

Signature:
This is the signature of the caregiver identified as the funded staff person. A signature in this area certifies that the information provided in the form and any supporting documentation required is accurate and true. **NOTE: the form will be returned where the original signature is missing.**

Date:
This is the date the form was completed, certified, and signed by the individual identified as Funded Staff Person. It is to be entered in YYYY/MM/DD format, e.g., where the date is September 28, 2018, the information must be entered as 2018/09/28.

For Office Use:
No information should be entered into this field. This space is for office use only.