DPHHS-HSC/CC-104a
Rev 7/07

STATE OF MONTANA
Department of Public Health and Human Services
Human & Community Services Division

2007-2008
MERIT PAY 1
PLAN OF STUDY SUMMARY

Best Beginnings
Montana DPHHS/
Child Care & Development Fund

Name_____PS NUMBER_____

Date of Birth_____SSN_____

Mailing Address _____ City_____Zip_____

Work Phone_____Home Phone_____

☐ ***Check here if this is a new address***

Name of Approved Training	Date Completed	Number Of Hours
	TOTAL HOURS	

Employer Certification:
I certify that _____is working 15 or more hours per week with children in the home or classroom setting in a licensed or registered child day care facility.

Signature of Director/Owner: _____**PV #**_____

I certify all information given is true and correct.

Applicant Signature: _____ **Date:** _____

Did you remember to include:
☐ Completed and signed Plan of Study Summary
☐ Copy of current Practitioner Registry Certificate
☐ Copy of training courses completed
☐ W-9

Merit Pay I participants must be actively working a minimum of 15 hours in a licensed/registered child care facility when payment is requested. Merit Pay I participants much attach verification of training completed and a copy of their MT Early Care & Education Practitioner Registry before payment will be released. Training can be verified and a copy printed at www.montana.edu/ecp/personnel using your PS number.