CAPS Child Care Provider

Repayment Hardship Request

Name of Child Care Provider:	Provider's County:
Date of Request:	Date of Claim Establishment:
Provider's ID#:	Tax ID #:
Claim Amount: $	# of Previously Established Claims:
Request for: ☐ Time extension ☐ Lower monthly repayment amount	
Office of Audit and Compliance Agent's Name and Email:	

The child care provider must send this request along with the following documents to the CAPS Program at CAPS.adverseactions@decal.ga.gov.

- ✓ **A letter requesting a reduction in percentage of payment offset and the reason for the needed reduction. The letter must be signed by child care program and dated.**
- ✓ **A copy of the signed CAPS Repayment Statement, if applicable.**
- ✓ **Note: all repayments are automatically set to allow overpayments to be paid in full within 24 months and will remain as such unless a repayment percentage reduction is granted.**

*****DECAL Child Care State Office Use Only*****

Disposition of Request Approved ☐	Approved % Rate for Reduction, (if applicable)	Length of time reduction is in effect	Authorized by:	Date Approved/ Denied	Date sent to SPMA
Denied ☐	$__________	_______ Months			
Justification:					

Original- SPMA   Copy- SO Provider File   Copy-County Claims File   Copy- A&C Agent