

### Exhibit 3: Provider Reimbursement Rates

Provider Name: \_\_\_\_\_

Provider Operational Hours: \_\_\_\_\_

PROVIDER must mark the appropriate box below indicating the appropriate provider type. In addition, PROVIDER must mark whether or not it has a Gold Seal Quality Care Designation. Finally, PROVIDER must complete the table below marked “To be completed by PROVIDER.” COALITION will complete the remainder of the Exhibit.

Does PROVIDER have a Gold Seal Designation?  Yes  No

#### PROVIDER’s Private Pay Rates (To be Completed by PROVIDER)

CARE LEVEL	(INF) <12 MTH	(TOD) 12<24 MTH	(2YR) 24<36 MTH	(PR3) 36<48 MTH	(PR4) 48<60 MTH	(PR5) 60<72 MTH	(SCH) In School	(SPCR) Special Needs If applicable
<b>Full-Time Daily Rates</b>								
<b>Part-Time Daily Rates</b>								
<b>Before or After School Rates</b>	N/A	N/A	N/A	N/A				

#### COALITION Maximum Reimbursement Rates (To be Completed by COALITION)

CARE LEVEL	(INF) <12 MTH	(TOD) 12<24 MTH	(2YR) 24<36 MTH	(PR3) 36<48 MTH	(PR4) 48<60 MTH	(PR5) 60<72 MTH	(SCH) In School	(SPCR) Special Needs
<b>Full-Time Daily Rates</b>								
<b>Full-Time Gold Seal Daily Rates</b>								
<b>Part-Time Daily Rates</b>								
<b>Part-Time Gold Seal Daily Rates</b>								
<b>Before or After School Rates</b>	N/A	N/A	N/A	N/A				
<b>Full-Time VPK Wrap Rate</b>	N/A	N/A	N/A	N/A			N/A	
<b>Part-Time VPK Wrap Rate</b>	N/A	N/A	N/A	N/A			N/A	