

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

REQUEST FOR PAYMENT CHILD CARE SERVICES

1. Name: _____ (Last) _____ (First)

2. Mailing Address: _____ (Street or P.O. Box)
 _____ (City, State) _____ (Zip) _____ (County)

3. Month Billed For: _____ 20 _____ to _____ 20 _____
 (First Day of Month) (Last Day of Month)

I certify that this is an accurate record of the attendance of all children in care. I understand that failure to keep accurate records may result in negative action to include corrective and/or legal action, referral for misrepresentation and/or requests for repayment of funds received as payment for subsidized children.

Provider Signature _____
 Date Submitted _____

(A) CHILD'S NAME - LINE a PARENT'S NAME - LINE b	(B) CHILD'S BIRTH DATE	(C) CHILD FEE	(D) DATE STARTED (New child)	(E) DATE CHILD LEFT CARE (Closed only)	(F) NUMBER OF DAYS			(G) OF TOTAL DAYS SHOWN, NUMBER THAT WERE NON-TRADITIONAL	(H) AGENCY USE ONLY (AMOUNT PAID)
					PART DAYS 1 min. to 1 hr. 59 min..	PART DAYS 2 hrs up to 3 hrs 59 min.	FULL DAYS of least 4 hours.		
1. a.									
b.									
2. a.									
b.									
3. a.									
b.									
4. a.									
b.									
5. a.									
b.									
6. a.									
b.									
7. a.									
b.									
8. a.									
b.									
9. a.									
b.									
10. a.									
b.									

WORKER SIGNATURE: _____ DATE PROCESSED: _____ TOTAL: _____