Child Care Assistance Billing Form

Child's name: Provider ID:

Case number: Provider name:

Service period: From _____ to _____

Provider instructions: Write in the information in the grid below for each child.

Unit Type: H = Hourly   **D** = Daily   **W** = Weekly   **O** = Other

NSH: Number of total hours that are eligible for the non-standard hour differential.

Age Group	Authorized Hours	Unit type	Number of units	Unit rate	Amount billed	Registration fees	Subtotal

Copay collected? ☐ Yes ☐ No   **Payment plan?** ☐ Yes ☐ No   **Family copay** $_____

Copay waived? ☐ Yes ☐ No   **Total** $_____

Daily schedule attendance record

Service period: From _____ to _____

Provider instructions: Write the date under each day listed on the grid. Indicate the scheduled number of hours and attendance code for each day. Leave the "Attendance" field blank if the child was with the provider on a scheduled day.

Attendance Codes: A = Absent day   **H** = Holiday

	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Total
Date															
Scheduled # of hours															
Attendance															