



## **Child Care Assistance Billing Form**

Date:		
Case name: Case number:		
To:	County name: County address: City, state, ZIP cod	le:
This billing is only valid for care giv	ven from to	
Complete the billing areas for each of should be returned to the county ag		attendance record. Completed billing forms
See the provider guide for details: ht	ttps://edocs.dhs.state.mn.us/lfserver/Pub	olic/DHS-5260-ENG
could face civil penalties and/or cr  I know I am responsible for collect pay their copay the family may be	tion on this billing form, I could be disq riminal charges. tting any copay amount owed from the f ineligible.	qualified from receiving CCAP payment and family. I understand that if the family fails to te child care was provided or the payment
PROVIDER SIGNATURE		DATE
Parent certification: I certify the child care billed is corre	ect and acknowledge the following:	1
■ I know that if I give false informat from CCAP and I could face civil	e e	information, my family could be barred
PARENT SIGNATURE		DATE
Provider comments:		
Call your worker if you need more i	information.	at

Child Care	Assistance	e Billing For	m					
Child's name: Case number:		Provider ID: Provider name:						
Service pe	riod: From _	to						
Provider in	nstructions	• Write in the in	nformation in th	e grid below fo	or each child.			
• •	•	•	<b>W</b> = Week ligible for the no	•				
Age Group	Authorized Hours	Unit type	Number of units	Unit rate	Amount billed	Registration fees	Subtotal	
Copay collect	ted? Yes	□ No	Payment plan	? Yes	No Fan	nily copay \$		
Copay waived?								
Service period Provider inst	<b>d:</b> From ructions: Wri	y. Leave the "At		olank if the chi	ld was with the			
Mor Date	ı Tue W	ed Thu Fri	i Sat Sun	Mon Tue	Wed Thu	Fri Sat	Sun Total	

Scheduled # of hours

Attendance