CHILD CARE PAYMENT REQUEST

Client Name: ______________________ Dates of Care: ______________

Child(rens) Name(s): ______________________________

Date	Hours of Care for each child a: Child #1	b: Child #2	Date	Hours of Care for each child a: Child #1	b: Child #2
1	a.	b.	16	a.	b.
2	a.	b.	17	a.	b.
3	a.	b.	18	a.	b.
4	a.	b.	19	a.	b.
5	a.	b.	20	a.	b.
6	a.	b.	21	a.	b.
7	a.	b.	22	a.	b.
8	a.	b.	23	a.	b.
9	a.	b.	24	a.	b.
10	a.	b.	25	a.	b.
11	a.	b.	26	a.	b.
12	a.	b.	27	a.	b.
13	a.	b.	28	a.	b.
14	a.	b.	29	a.	b.
15	a.	b.	30	a.	b.
			31	a.	b.

SAMPLE

Total Hours of Care Provided: Child a: ______________ Child b: ______________

When billing for scheduled care, make note of the day(s) that the child was absent below.

I attest that the above hours are true and have already been provided. Furthermore, I attest there is no other assistance including federal, state, or local assistance being received/provided for the same costs. I understand I may owe money to SCB if the amount paid to me is incorrect.

Signature of Provider ______________________ Rate of Pay ______________

I ______________________ certify the above hours of day care is correct, and have already been provided. I understand I may owe money to SCB if the amount paid to the provider is incorrect.
(client's name)

Client's Signature ______________________ Phone No. ______________

	Certified center rate (CNT)		
	Hourly	Part–time	Monthly
Infant	$6.50	$893	$1,190
Toddler	$6.25	$812	$1,083
Preschool	$5.75	$645	$860
School	$5.15	$472	$629

************* SCB OFFICE USE ************

Part-time Rate: 63-135 hours, may include 5 absent days

Full-time rate: 136 hours, may include 5 absent days

______________ X ______________
No of Hours /QTY Rate: HR/PT/FT

= ______________