

CHILD CARE BILLING STATEMENT

For timely and accurate reimbursement by the Department for Community Based Services (DCBS) Protection and Permanency (P&P), the provider of child care for foster children shall fill out and submit the information on this form on each child that attends your facility on a monthly basis. The completed form, including all required information should be submitted with the provider's original signature.

Provider Name: _____

Complete Mailing Address: _____

Phone Number _____ Licensed _____ Certified _____ Registered/Private _____

Child's Last Name	Child's First Name	Service Mo/Yr	# of days billed	Full Day Part Day	Daily Rate	Total Charges to DCBS
				<input type="checkbox"/> Full Day <input type="checkbox"/> Part Day		
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CERTIFICATION STATEMENT FOR PROVIDER: I certify that the information provided is accurate. Knowingly reporting of false information is subject to criminal and civil penalties.

Signature of Provider

Title

Date

Please remit invoice to: