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)

Provider Signature

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 0-2 HRS.	PART DAYS 2-4 HRS.	FULL DAYS 4 OR MORE HRS		
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:**

ECE-CC-10A
10/03

Please refer to the payment form instructions in completing this form.