Sacramento County Child Care Payment Request Form

--Use One Form For Child – PLEASE MAIL THIS FORM TO: DHA PO BOX 487 SACRAMENTO, CA 95812-9874

Month/Year of Care:

Please sign child in and out of care daily. The first initial of your first name and your last name are required.

- **Do not use "white-out". Days marked with "white-out" will not be paid.**
- Only list hours of care the child actually used each day.
- Both sides of this payment request form must be completed, signed and dated on or after the last day care was provided.
- Payment will be delayed if this form is incomplete.
- Each day the child does not use care as scheduled, enter one of the following codes in the "Code" box on the reverse side and include the number of hours the child had been scheduled to attend daycare. **These codes are for licensed providers only**.

Provider Closed All or Part of the Day	Child or Parent ill and Child did not Attend Daycare	Child Absent for Other Reasons	School-Age Child did not Attend School Due to Illness but did Attend Daycare	Minimum Day	Non-school Day
C	**S**	**A**	**D**	**M**	**NS**

Parent Information: (To be completed by parent)	**Child Information:**	**County Use:**
Parent 1 Name:	Child's Name:	**WTW HSS Code:** _____
Parent 1 Activity: □ Employment □ School □ CWEX □ JC	Child's Home Address:	**Case Name:** _____
Activity Schedule:	Phone #:	**Case #:** _____
Activity Address:	School:	**Date Received:** _____
Parent 2 Name (if in the home): □ not in home	Grade:	**Timesheet #** _____
Parent 2 Activity: □ Employment □ School □ CWEX □ JC	Date of Birth: / Age:	**Family ID** _____
Activity Schedule:	Parent Mode of Transportation: □ Drive □ Walk □ Bus	**Child ID** _____
Activity Address:	□ Other _____	**Provider ID** _____
Travel Time: From day care to activity is _____ minutes each way.		

Child Care Provider Information: (To be completed by provider)

Type of Facility:
□ Child Care Center □ Licensed Family Child Care Home □ Trustline Provider □ Relative

Provider Name:		DBA (Doing Business As Name):
Address Where Care is Provided: □ *New Address*		Provider Billing Address: □ *New Address*
City, State & Zip:		Day Care License Number:
Phone:	If relative, relationship:	Last four digits of provider's SSN or Tax ID if incorporated

Child Care Provider Billing: (To be completed by provider)

Please fill out your billing amount in the appropriate categories. All charges must match what appears on your rate sheet if you wish payment to be made.

□ Monthly Rate: $ _____ Weekly Rate: $ _____

□ Daily Rate: $ _____ Hourly Rate: $ _____

□ Evening Rate: (6:00 pm to 6:00 am) $ _____ Sat/Sun Rate: $ _____

□ Registration Fee for licensed providers as charged per rate sheet: $ _____

Month Annual Registration is due as billed per Rate Sheet: _____

Total billed for this month for child $ _____

IMPORTANT NOTICE:
RETURN THIS FORM BY THE 5TH DAY OF THE MONTH FOLLOWING THE MONTH CHILD CARE WAS PROVIDED. BOTH SIDES OF THIS PAYMENT REQUEST FORM MUST BE COMPLETED, SIGNED AND DATED BY BOTH THE PROVIDER AND THE PARENT, ON OR AFTER THE LAST DAY CARE WAS PROVIDED.

I declare under penalty of perjury under the laws of the United States and the State of California that the facts contained in this payment request form are true and correct and complete for the entire month.

Parent Signature _____ Date _____ Provider Signature _____ Date _____

To be completed by parent:

Month/Year

Start on the 1st day of care in the month, sign your child in and out daily by filling in the date of care, the time the child was dropped off and picked up and your signature (first name initial and last name). For each day when care was provided, fill in the total daily hours of care in the "Hours" box. Also, fill in the hours scheduled for any absence days. At the end of each week, fill in the "Total Hours" box listed in the left column.

	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
Date														
Time In														
Signature														
Time Out														
Signature														
Total Hours	Hours	Code	Hours	Code	Hours	Code	Hours	Code	Hours	Code	Hours	Code	Hours	Code
Date														
Time In														
Signature														
Time Out														
Signature														
Total Hours	Hours	Code	Hours	Code	Hours	Code	Hours	Code	Hours	Code	Hours	Code	Hours	Code
Date														
Time In														
Signature														
Time Out														
Signature														
Total Hours	Hours	Code	Hours	Code	Hours	Code	Hours	Code	Hours	Code	Hours	Code	Hours	Code
Date														
Time In														
Signature														
Time Out														
Signature														
Total Hours	Hours	Code	Hours	Code	Hours	Code	Hours	Code	Hours	Code	Hours	Code	Hours	Code
Date														
Time In														
Signature														
Time Out														
Signature														
Total Hours	Hours	Code	Hours	Code	Hours	Code	Hours	Code	Hours	Code	Hours	Code	Hours	Code

Total hours of care this month ______________________________

I declare under penalty of perjury under the laws of the United States and the State of California that the facts contained in this payment request form are true and correct and complete for the entire month.

______________________________ Parent Signature

____________ Date

______________________________ Provider Signature

____________ Date