

## West Virginia Department of Human Services REQUEST FOR PAYMENT CHILD CARE SERVICES

1. Name:					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.				
(Last) (First)									
2. Mailing Address:									
(Street or P.O. Box)									
(City, State) (Zip)			(County)		Provider Signature				
Nonth Billed For: to		to	, 20		Provider ID#				
(First Day of Month)			(Last Day of Month)						
					Provider ID# _				
					(F)				
(A) CHILD'S NAME - LINE a	(B) CHILD'S	(C) CHILD FEE	(D) DATE STARTED (New child)	(E) DATE CHILD LEFT CARE (Closed only)	NUMBER OF DAYS			(G) OF TOTAL DAYS	(H) AGENCY USE
PARENT'S NAME - LINE b	BIRTH DATE				PART DAYS 1 min. to 1 hr. 59 min.	PART DAYS 2 hrs. up to 3 hrs. 59 min.	FULL DAYS at least 4 hrs.	SHOWN, NUMBER THAT WERE NON- TRADITIONAL	ONLY (AMOUNT PAID)
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.									
INVOICE # W	ORKER SIGNATU	JRE:				DATE PROCES	SED://_	TOTAL:	