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 1 min. to 1 hr. 59 min..	PART DAYS 2 hrs up to 3 hrs 59 min.	FULL DAYS at least 4 hours .		
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:**

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