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**. All children can be listed on the same invoice. The completed form, including all required information should be submitted with the provider's original signature.

Provider Name:____

Physical Address:____County:____________________

Phone Number: ________________________________ Email Address:___________________________________

Please check one: Licensed I ☐ Licensed II ☐ Certified ☐ Registered/Private ☐

Child's Last Name	Child's First Name	Service Month/Yr	# of days billed	Full Day Part Day	Daily Rate	Total Charges to DCBS
				☐ Full Day ☐ Part Day		
				☐ Full Day ☐ Part Day		
				☐ Full Day ☐ Part Day		
				☐ Full Day ☐ Part Day		
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				☐ Full Day ☐ Part Day		
				☐ Full Day ☐ Part Day		

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: **/ Billing Specialist**