



**West Virginia Department of Health and Human Resources  
REQUEST FOR PAYMENT CHILD CARE SERVICES**

1. Name: \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ **Provider Signature**

2. Mailing Address: \_\_\_\_\_ (Street or P.O. Box) \_\_\_\_\_ (City, State) \_\_\_\_\_ (Zip) \_\_\_\_\_ (County) \_\_\_\_\_

3. Month Billed For: \_\_\_\_\_ 20 \_\_\_\_\_ to \_\_\_\_\_ 20 \_\_\_\_\_ (Last Day of Month) \_\_\_\_\_ **Date Submitted**

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 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, 6/2015 Please refer to the payment form instructions in completing this form.