NIAGARA COUNTY DEPARTMENT OF SOCIAL SERVICES
P.O. BOX 506
Lockport, New York 14095-0506

REQUEST FOR PAYMENT OF DAY CARE SERVICES
TO BE COMPLETED BY CHILD CARE PROVIDER (LICENSED OR REGISTERED)

Care Provided
From: Month _____Day_____Year_____to Month_____Day_____Year_____

Case Name _____ Provider Name _____

Case Number _____ Vendor Number _____

Child's Name _____ Provider Address _____

_____

****Bills must be received by the Agency within 90-days from date of services to be eligible for processing.**

ACTUAL DATE OF SERVICE	TIME IN/OUT	TOTAL HOURS	P = Present A = Absent C = Program Closed (indicate reason)
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BY SIGNING BELOW, I AM CERTIFYING THAT THE INFORMATION ON THIS FORM IS TRUE AND THAT THE CHILD CARE SERVICES LISTED WERE PROVIDED AND BILLED CORRECTLY

CHILD CARE PROVIDER SIGNATURE DATE

CLIENT SIGNATURE DATE

***PARENT'S RESPONSIBILITY* TO REVIEW AND SIGN THE BACK OF THE DAYCARE BILLS ATTESTING TO THE HOURS BEING BILLED FROM THE DAYCARE PROVIDER. **DO NOT SIGN THE BILL PRIOR TO THE END OF SERVICE FOR THE MONTH** IF YOU DO NOT AGREE WITH THE HOURS BEING BILLED, DO NOT SIGN UNTIL THE DISCREPANCY HAS BEEN CORRECTED.**

THIS SPACE FOR OFFICE USE ONLY

AMOUNT _____ **PERIOD COVERED** _____ **TO** _____

APPROVED BY:

_____ _____

SIGNATURE OF DSS DAY CARE WORKER **DATE**