CHILD CARE ATTENDANCE/CLAIM SHEET

The Resource Connection

Engaging Families ▪ Empowering Communities ▪ Enriching Lives

AMADOR:
10877 Conductor Blvd., P.O. Box 216
Sutter Creek, CA 95685
(209) 223-1624 - (209) 223-2188

CALAVERAS:
501 F Gold Strike Rd., P.O. Box 919
San Andreas, CA 95249
(209) 754-3048 - (209) 754-1075

PRINT PROVIDER'S FULL NAME (1)

PROVIDER'S MAILING ADDRESS

PROVIDER'S PHONE NUMBER

PRINT CHILD'S FULL NAME

PRINT PARENT'S FULL NAME

FOR MONTH / YEAR

FORM COLOR (2)

[_]PURPLE / [_] BLUE / [_] YELLOW

DATE	TIME IN (3a)	PARENT/RESPONSIBLE ADULT FULL SIGNATURE OR REASON FOR ABSENCE (3b)	INTERRUPTION OF CARE				TIME OUT (3c)	PARENT/RESPONSIBLE ADULT FULL SIGNATURE (3d)	# OF HOURS (4)		OFFICE USE ONLY
			OUT	INITIAL	IN	INITIAL			USED	CONTRACTED	
1											1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
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25											25
26											26
27											27
28											28
29											29
30											30
31											31
		TOTAL:									

(STAMP DATE RECEIVED ABOVE)

PARENTS & PROVIDERS:
This is a "Partial Pay Program".
Days with missing in or out times,
or incomplete signatures **will not be reimbursed**
by The Resource Connection

(6a)

PARENT VERIFICATION:
I CERITIFY UNDER PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM IS TRUE AND CORRECT.

Parent Signature _____ Date _____

(6b)

PROVIDER VERIFICATION::
I certify under penalty of perjury that all the information is true and correct and that I charge the same rates to all clients regardless of their subsidized or non-subsidized status.

Provider Signature _____ Date _____

PAYMENT REQUESTED # UNITS	x RATE	= TOTAL	OFFICE USE ONLY PAYMENT ISSUED
OTHER			
TOTAL $$ DUE:			

BID		CAPP		CDSSA	
COV		C2AP		CDSSC	
DPPI		C3AP		CFCC	
DPPA					

Subsidy Coordinator Initals