CHILD CARE ASSISTANCE PROGRAM
PASS II and PASS III
IN-HOME BILLING REPORT FORM

STATE of ALASKA
DEPARTMENT of HEALTH AND SOCIAL SERVICES

FOR OFFICE USE ONLY
DATE RECEIVED

1 Parent Name: ______________________________

Mailing Address: ______________________________

City: ______________________ Zip: ____________

2 Home Phone: ______________ Work Phone: ______________

3 Care provided during the month of: ______________________

4 In-Home Provider Name: ______________________

5 Child's Full Name | 6 Age | 7 Fill in the dates of care for the month. | 8 Total Units | 9 State Rate | 10 State Rate - | 11 Family Contribution Amount | = 12 State Payment Amount

Child's Full Name	Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	P	F	H		Rate	Total	State Rate -	Family Contribution Amount	State Payment Amount
	I T																																			P					
	P S	13 Authorized Care (circle one): Enrollment / Attendance																																		F					
																																				H					

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PARENT CERTIFICATION

I certify that the information provided on this form is true and correct, that I was engaged in eligible activites during the hours I am billing for on this form, and that I have complied with all federal and state wage requirements and tax withholding and reporting requirements as the employer of my in-home provider.

Parent Signature ______________________ Date ________

IN-HOME PROVIDER CERTIFICATION

I certify that I provided child care to the children listed above during the hours reported on this form.

In-Home Provider Signature ______________________ Date ________

16 Comments: ______________________________

17 Totals for this page | | |

18 Totals for all pages | | |

19 Page ______ of ______