CHILD CARE ASSISTANCE PROGRAM PASS II and PASS III MONTHLY BILLING REPORT FORM

1 ☐ Initial Billing
☐ Amended Billing

2 **For services provided during the month of:** ____________________

3 Owner/Provider Name: ____________________

Facility Name: ____________________

4
☐ Licensed Center
☐ Licensed Group Home
☐ Licensed Home
☐ Approved Provider
☐ Approved Relative

5 **ICCIS#** ____________________

PVN: ____________________

Mailing Address: ____________________
Address changes will not be made from this billing form. Contact your Child Care Assistance office.

City: ____________ Zip: ______ Phone: ____________

DO NOT USE CORRECTION FLUID OR ERASE ON THIS FORM

6 7 8 *fill in rates for units you are billing* 9

	Last Name	First Name	I T P S	Total Provider Charge: PT	FT	Hours	Total	Copay
C								
P								

10

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

11 AK-IN Supplemental/Registration Request/Comments/Notes:

For CCA Use Only

	Units	Rates	Total	Subsidy Amount
Attn	P/F			
Enroll	P/F			
Registra	H			
Lower: Provider State	Notes:			

	Last Name	First Name	I T P S	Total Provider Charge: PT	FT	Hours	Total	Copay
C								
P								

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

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	Units	Rates	Total	Subsidy Amount
Attn	P/F			
Enroll	P/F			
Registra	H			
Lower: Provider State	Notes:			

12 I certify that the information provided on this form is true and correct and that the parents listed on this form have agreed upon arrangements.

Authorized Signature   Date:

Total To Pay: $ ____________

By: **Date:**