DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC ASSISTANCE

PASS I CHILD CARE BILLING REPORT

for the month of: ______________

Owner/Provider: ______________________

Facility Name: ______________________

Mailing Addresss: ______________________

Federal Tax ID or SSN: ______________ City/Zip: ______________

Vendor Number: ______________ Phone:(907) ______________

	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	TOTAL UNITS BILLED P	F	H	Circle One	SCALE	RATE	TOTAL AMOUNT
CHILD																																			Enroll Attn	I	P	
PARENT																																				T C	F	
																																				S	H	
CHILD																																			Enroll Attn	I	P	
PARENT																																				T C	F	
																																				S	H	
CHILD																																			Enroll Attn	I	P	
PARENT																																				T C	F	
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CHILD																																			Enroll Attn	I	P	
PARENT																																				T C	F	
																																				S	H	
																																					SUBTOTAL	
																																					TOTAL:	$

Comments:

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I certify this information is true and correct:

______________________ ______________
PROVIDER SIGNATURE DATE

______________________ ______________
DEPARTMENT SIGNATURE DATE

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CC 5 (06-3817) 11/01

ORIGINAL - LOCAL PUBLIC ASSISTANCE OFFICE YELLOW COPY - PROVIDER