The following form can be filled out **Online,** printed for signatures, then mailed or faxed.

To fill out forms in Acrobat Reader:

- Select the “hand” tool.
- Click on a line or in a box and begin typing.
- Check boxes can be clicked on or off.
- To move from one editable area to the next, use the tab key.
- If you prefer, the “Highlight Fields” option can be selected to show the editable areas on the form, and the zoom tool in the browser can be used to enlarge the form view.
- When printing the form, start with page 2 of this PDF document.
- For best results, we recommend the lastest version of Acrobat Reader.

Community Colleges of Spokane

Spokane County Head Start/ECEAP/EHS
CHILD CARE REIMBURSEMENT VOUCHER

Reset form

Parent/Guardian name _____ HS/EHS/ECEAP Site: _____

Address _____ City _____ State _____ ZIP _____

Phone _____

Child(ren)'s name(s) _____

TOTAL AMOUNT DUE $ _____
(From worksheet on back)

Check one:

❒ I have NOT paid the child care provider for completed child care services.

❒ I HAVE paid the child care provider in full for child care services provided. I understand I will receive a reimbursement check from the WA Community College District 17 within three weeks of their receipt of this completed voucher request.

I understand the child care provider must have a completed W-9 form on file with the Community Colleges of Spokane (CCS) in order for reimbursement to be made to either the child care provider or myself.

FOR CHILD CARE PROVIDER TO COMPLETE:

Provider's name (please print) _____

Address _____ City _____ State _____ ZIP _____

Phone _____

Check one:

❒ I have received payment in full from the parent/guardian for child care services provided.

❒ I have NOT received payment for child care services I have provided. I understand that I will receive a reimbursement check from WA Community College District 17 within three weeks of their receipt of this completed voucher request.

I understand I must have a completed W-9 form on file with the Community Colleges of Spokane (CCS) in order for reimbursement to be made to either the parent/guardian or myself.

I certify I have provided child care services for the child(ren) noted above and these charges are at my normal and usual rate for such services. I also certify all of the information is true and accurate to the best of my knowledge.

Signature of provider _____ Date _____

I certify under penalty of perjury that this is a true and correct claim for necessary and approved expenses incurred by me.

Parent/Guardian signature _____ Date _____

Staff approval _____ Date _____

Budget number _____

CHILD CARE PAYMENT WORKSHEET

DATE OF CARE	REASON FOR CHILD CARE	FROM TIME:	TO TIME:	NUMBER OF HOURS	NUMBER OF CHILDREN

CHILD CARE RATES

NUMBER OF CHILDREN	RATE PER HOUR
1	$7.00
2	$7.50
3	$8.00
4 or more	$8.50

Out-of-town rate:
24 hour maximum=base for 1 child: $56
Add $5 per child to base rate

Total reimbursable hours:		x rate of reimbursement	$	=	$
		x rate of reimbursement	$	=	$
		x rate of reimbursement	$	=	$
		x rate of reimbursement	$	=	$
			TOTAL AMOUNT DUE*	=	**$**

Transfer TOTAL AMOUNT DUE to front of form.