County: LARIMER

Child Care Attendance Record and Billing Form

Month / Year ______________________

PAGE: ________ of ________

Provider Legal Name: ______________________

Address: ______________________

City, State, Zip: ______________________

Provider ID / License # ______________________

	Rate	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 days used	x	Rate per day	=	Sub total	Subtract	Parent fee	Total
Child Name	F																																							
	P																																							
Child Auth / Tech	V																																							
State ID	T																																							
REASON FOR BILLING ->		County Error____ System Error_____ Other: Adjustment #																																		parent fee paid (Yes / No)			
Child Name	F																																							
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REASON FOR BILLING ->		County Error____ System Error_____ Other: Adjustment #																																		parent fee paid (Yes / No)			

TOTAL $ -

I certify that the above Child Care Attendance Record and Billing Form is accurate and complete for care actually provided and for which payment has not been received through the automated sytem ATS. I understand and certify that I am in compliance with the law concerning discrimination under the Civil Rights Act of 1964 and Section 504, Rehabilitation Act of 1973 which prohibits payment to anyone providing care and services under federally assisted programs unless such services are provided without discrimination on the basis of race, color, sex, age, religion, political beliefs, national origin, or handicap. I further certify that I am not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department.

FOR COUNTY USE ONLY.

Human Services Designee

Provider Signature ______________________ Date ________

( )

Phone Number

PRINT E-mail address

How to Complete the Child Care Attendance Record and Billing Form

1) Please be sure to complete your Provider Information by printing your name, address, phone number, e-mail address and provider ID or provider license number.

2) This is a legal document. Please retain a copy for your records

3) The Attendance Record and Billing Form **must be completed in black or blue ink** and returned to the county department within 60 days per contract. If you do not turn in your billing form within two months, you will not be paid for those services.

4) After manual claims are processed, the payment amount will be e-mailed to you.

5) The month you are billing for must be in the top right corner.

6) **Only one month per billing form.**

7) Larimer County requires the number of hours the authorized child was in care each day. **Do not put** an "X", **"F", "P",** "V", "T", etc.
If less than 5 hours, write the number of hours on the "P" line. If 5 or more hours write the number of hours on the "F" line.
For Other rates - less than 5 hours, write the number of hours on the "T" line. If 5 or more hours write the number of hours on the "V" line.

F	<- USE THIS LINE TO WRITE IN FULL TIME DAYS~ OVER 5 HOURS
P	<- USE THIS LINE TO WRITE IN PART TIME DAYS~ UNDER 5 HOURS
V	<- USE THIS LINE TO WRITE IN FULL TIME NIGHTS/WEEKENDS~ OVER 5 HOURS
T	<- USE THIS LINE TO WRITE IN PART TIME NIGHTS /WEEKENDS~ UNDER 5 HOURS

Evening Care: When 50% or more of the total time that the children are in care is between the hours of 6:31 pm and 5:59 a.m.

Weekend Care: Care given to children between the hours of 6:31 p.m. Friday and 5:59 a.m. Monday.

Overnight Care: . A daily rate used when care provided spans the midnight hour

Always complete the "total days used", "subtotal", and "total amount to be reimbursed" sections and sign and date your bill.

Please send your completed billing form to:

ATTN: Child Care Billing
Larimer County Department of Human Services
1501 Blue Spruce Drive
Fort Collins, CO 80524

OR

Email your completed billing form to: ggraham@larimer.org

Additional forms are available here: larimer.org/dhs/assistance/ccap_provider_forms.htm