Child Care Attendance Manual Claim Form

This is a legal document. Please keep a copy for your records.

Complete and submit the manual claim form to address payment discrepancies if or when:

- After reconciling and reviewing the *Weekly Payment Summary* (CR205) report in ATS and confirming the discrepancies for each CCCAP child in your care.
- You believe your weekly automated payroll is missing payment for authorized CCCAP child care.
- You have been pre-approved for an ATS waiver.

The manual claim form must be completed and submitted to your County CCCAP office within 60 calendar days of the care month. If completing manually it must be done in ink. If filling out the manual claim digitally, fields will be enabled if you have Adobe Acrobat Reader installed on your device.

Attendance records must be submitted with your manual claim form. The Daily Sign-In/Out Log (RE753) from the Attendance Tracking System (ATS) can be printed and be used as a verified attendance record by submitting with the parent's signature for days claimed.

Submit one manual claim form packet for each month, entering each child with a discrepancy on their own page.

INSTRUCTIONS and a SAMPLE manual claim form has been provided for your review on pages **5** and **6**.

Enter the information in each field below. This information will automatically populate on each page of the manual claim packet.

Month, Year		**Address**	
County			
Provider Name		**Phone**	
Provider ID		**Email**	

For county use only: County Adjustment ID _____ County Invoice Number: _____ Date Processed: _____

Month: _____ Address: _____ County Adjustment ID: _____

County: _____ County Invoice Number: _____

Provider Name: _____ Phone: _____ Date Processed: _____

Provider ID: _____ Email: _____

CHILD 1

Child's Name: _____ Child's Age: _____ Case Number: _____

Reason: _____

1 none	2 none	3 none	4 none	5 none	6 none	7 none	8 none	9 none	10 none	11 none
12 none	13 none	14 none	15 none	16 none	17 none	18 none	19 none	20 none	21 none	22 none
23 none	24 none	25 none	26 none	27 none	28 none	29 none	30 none	31 none		

Total Days Used	×	Rate Per Day	=	Sub-Total	—	Parent Fee	=	Claim Amount (**CHILD 1**)
_____		_____		$ 0.00		◉ Yes ○ No _____		$ 0.00

CLAIM TOTAL $ 0.00

I certify that the above manual claim request is accurate and complete for authorized CCCAP child care provided by me and for which payment has not been received through the automated payroll system. 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.

Name of the person completing this form:

Signature:

Today's Date:

Month: _____ Address: _____ County Adjustment ID: _____

County: _____ County Invoice Number: _____

Provider Name: _____ Phone: _____ Date Processed: _____

Provider ID: _____ Email: _____

CHILD 2

Child's Name: _____ Child's Age: _____ Case Number: _____

Reason: _____

1 none	2 none	3 none	4 none	5 none	6 none	7 none	8 none	9 none	10 none	11 none
12 none	13 none	14 none	15 none	16 none	17 none	18 none	19 none	20 none	21 none	22 none
23 none	24 none	25 none	26 none	27 none	28 none	29 none	30 none	31 none		

Total Days Used × Rate Per Day = Sub-Total − Parent Fee = Claim Amount (**CHILD 2**)

(●) Yes ( ) No

_____ _____ $ 0.00 0.00 $ 0.00

CLAIM TOTAL $ 0.00

I certify that the above manual claim request is accurate and complete for authorized CCCAP child care provided by me and for which payment has not been received through the automated payroll system. 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.

Name of the person completing this form: **Signature:** **Today's Date:**

Month: _____ Address: _____ County Adjustment ID: _____

County: _____ County Invoice Number: _____

Provider Name: _____ Phone: _____ Date Processed: _____

Provider ID: _____ Email: _____

CHILD 3

Child's Name: _____ Child's Age: _____ Case Number: _____

Reason: _____

1 none	2 none	3 none	4 none	5 none	6 none	7 none	8 none	9 none	10 none	11 none
12 none	13 none	14 none	15 none	16 none	17 none	18 none	19 none	20 none	21 none	22 none
23 none	24 none	25 none	26 none	27 none	28 none	29 none	30 none	31 none		

Total Days Used	×	Rate Per Day	=	Sub-Total	—	Parent Fee	=	Claim Amount (**CHILD 3**)
_____		_____		$ 0.00		◯ Yes ◉ No _____		$ 0.00

CLAIM TOTAL $ 0.00

I certify that the above manual claim request is accurate and complete for authorized CCCAP child care provided by me and for which payment has not been received through the automated payroll system. 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.

Name of the person completing this form:

Signature:

Today's Date:

MANUAL CLAIM EXAMPLE (Legend presented on the next page)

Month:	September-2025	**Address:**	0909 Somewhere St.	**County Adjustment ID:**	
County:	Rio Blanco		Meeker, CO 81641	**County Invoice Number:**	
Provider Name:	The Best Provider	**Phone:**	970-909-0909	**Date:**	
Provider ID:	0909090	**Email:**	the.best.provider@email.com		

1

CHILD 1

Child's Name: Mary Jane Smith **Child's Age:** 6 months **Case Number:** 0909090

Reason: Enter the reason for submitting a Manual Claim

2

1 FT 40.00	2	3	4	5 PT 25.00	6	7 FT 40.00	8	9	10	11
12	13	14	15 FT 40.00	16	17	18	19	20 PT 25.00	21 FT 40.00	22
23	24	25	26	27	28	29	30	31		

3

4

Total Days Used	× Rate Per Day	= Sub-Total	− Parent Fee	= Claim Amount (CHILD number)
(FT) 4	40.00		● Yes ○ No	
(PT) 2	25.00	210.00	20.00	$ 190.00

5

6

CLAIM TOTAL $

7

8

Name of the person completing this form: Write name in print of the person completing the form

Signature: Sign after reading the acknowledgement statement

Today's Date: Date after reading the acknowledgement

LEGEND

1. If completing the manual claim digitally, this section automatically populates with the information entered on page 1.
2. Enter information about each child with a payment discrepancy on a separate page.
3. Using the following codes, indicate the amount of authorized care that was provided for each day of the month:
    - PT = part time (0 hours 1 second – 5 hours)
    - FT = full time (5 hours 1 second – 12 hours)
    - FTPT = full time/part time (12 hours 1 second – 17 hours)
    - FTFT = full time/full time (17 hours 1 second – 24 hours)
    - A = absence
    - H = holiday
    - L = hold slot
4. Reference your rate schedule from your County Fiscal Agreement to determine the daily rate for the corresponding child on this claim (based on child age and authorized rate type). Type the correct rate amount into the field for each day authorized care was provided but not paid correctly.
5. Calculation:
    - **'Total Days Used'** and **'Rate Per Day'**: if filling out the manual claim form digitally, these fields will not automatically populate. These are here only for your reference if you need to calculate the claim amount manually.
    - **'Sub-Total'**: when multiplying the total days used and rate per day, this will give you the sub-total. If filling out the form digitally, the form will calculate the sub-total automatically.
    - **'Claim Amount (CHILD number)'**: This is the dollar amount you are requesting reimbursement for (***NOTE***: this is only for one child). If filling out the form digitally, the form will calculate this amount for you.
6. 'Parent Fee': If the family pays a monthly Parent Fee, indicate whether it was paid by selecting "Yes" or "No". Then enter the Parent Fee dollar amount. When a dollar amount is entered in this field, the form will automatically subtract the Parent Fee from the claim amount.
7. This is the sum of all manual claims in this packet ('Claim Amount (CHILD 1)' + 'Claim Amount (CHILD 2)' + 'Claim Amount (CHILD 3)' = 'CLAIM TOTAL').
8. **'Signature'**: You can sign the form in multiple ways:
    - Setting up a certified digital signature with a ***password*** (make sure you include the Adobe Acrobat logo, it will appear behind your signature as a watermark).
    - Setting up a signature by ***drawing it*** with your finger or mouse on the screen (NOTE: use the button "***Draw***" do ***NOT*** use the button 'Type').
    - You can print the form and sign it by hand.