CHILD CARE BILLING REPORT

ND DEPARTMENT OF HUMAN SERVICES
ECONOMIC ASSISTANCE
SFN 616 (Rev. 11-2011)

Clear Fields

IF THIS FORM IS NOT FILLED OUT ENTIRELY, IT WILL BE RETURNED.

Date of Service: (Month/Year)	

Name of Parent	Social Security Number (SSN)*	Address	Check if Change of Address ☐	Telephone Number
Name of Provider	Tax ID of Provider (SSN or EIN)	Provider's Address	Check if Change of Address ☐	Telephone Number
How is Day Care Billed? (Check Method of Billing) ☐ Hourly ☐ Daily ☐ Weekly ☐ Semi-Monthly ☐ Monthly		Amount	Will you be providing child care for this family next month? ☐ Yes ☐ No	

Check Type of Care Provided (Letter on Provider Number)
AR ☐ Approved Relative - (Q) TR ☐ Tribal Registration - (R) RF ☐ Relative in Family Day Care - (F,I) CT ☐ Center - (C,E,K,M)
SD ☐ Self Declaration - (S) NF ☐ Nonrelative in Family Day Care - (F,I) NG ☐ Group Care - (G,H)

* The Provider must enter the actual hours they provided care for each child.
** The Provider must enter the actual hours charged for a child who is ill and not at child care. **(Do not include hours the provider or parent(s) is ill or on vacation.)**
*** The Parent must enter the actual hours participated in their approved Child Care Assistance Program activity for each child **while the child was in the provider's care.**

Child's Name | Age | Amount Due

	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 Hours**
* **Provider's** Actual Child Care Hours Provided:																																
** Charged Hours when Child is ill																																
***Actual hours **Parent(s)** participated in Approved Activity while child was in care (include travel time)																																

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I hereby certify that the information, including the **actual hours** of care provided, on this form is true and complete to the best of my information and knowledge. I certify that both parties **signed and dated** the form **after it was completed**. I agree to promptly report to the county social service office any change or correction in the information shown on this form. I further agree that if this form or the parent listed is selected for field review, my signature below constitutes my consent to obtain verifying information from any necessary source. I certify that I have not billed this parent more than I billed private pay clients.

Total Amount Due:

Provider's Signature:	Date:	Parent's Signature:	Date:

PARENT: * Disclosure of the Social Security Number (SSN) is voluntary and is requested for the purpose of accurate identification. Failure to disclose the SSN will not affect participation in this program.

PROVIDER: Disclosure of the Social Security Number or Employer Identification Number is required pursuant to 26 CFR 301.6109-1 and is requested for the purpose of reporting tax information. Failure to disclose this information may result in no payment being made.

DISTRIBUTION: ORIGINAL: County Social Service Office **COPY**: Child Care Provider **COPY**: Parent

KEEP THIS STATEMENT FOR YOUR TAX RECORDS