

**TUSCARAWAS COUNTY JOB & FAMILY SERVICES
CHILD CARE INVOICE FOR FOSTER CHILD**

Month: _____ **Year:** _____ **Child's Name:** _____

Provider Name: _____ **Foster Parent:** _____

Mailing Address: _____ **Foster Parent:** _____

☐ **IV-E** ☐ **Non-IV-E** **Child's Age:** _____

NOTE: The only hours billable to this program are when **both** foster parents are at work or engaged in a required activity.

NOTE: Please round begin and end times to the nearest quarter hour (:00, :15, :30, :45).

DAILY ATTENDANCE DATES/TIMES

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
Date							
Begin Time							
End Time							
Hours Worked							
Date							
Begin Time							
End Time							
Hours Worked							
Date							
Begin Time							
End Time							
Hours Worked							
Date							
Begin Time							
End Time							
Hours Worked							
Date							
Begin Time							
End Time							
Hours Worked							

ITEMIZATION

Registration Date: _____ and Fee: _____ = _____

Miscellaneous (explain): _____ and Fee: _____ = _____

Number of Hours: _____ X Unit Rate: _____ = _____

Number of Part-time Weeks: _____ X Unit Rate: _____ = _____

Number of Full-time Weeks: _____ X Unit Rate: _____ = _____

TOTAL COST/PAID AMOUNT = _____

Approved by Business Office _____

Business Office Codes: _____

Return to:	Tuscarawas County Job & Family Services Business Office 389 16 th Street, SW New Philadelphia, Ohio 44663
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