Provider: Child Name: Case #:

Billing Period: Parent Name:

Iowa Department of Human Services

Child Care Assistance Billing/Attendance

		1	2	3	4	5	6	7	8	9	10	11	12	15	30	45	A	P		1	2	3	4	5	6	7	8	9	10	11	12	15	30	45	A	P	Absent
Mon., Jun 29	In																		In																		
	Out																		Out																		
Tue., Jun 30	In																		In																		
	Out																		Out																		
Wed., Jul 1	In																		In																		
	Out																		Out																		
Thu., Jul 2	In																		In																		
	Out																		Out																		
Fri., Jul 3	In																		In																		
	Out																		Out																		
Sat., Jul 4	In																		In																		
	Out																		Out																		
Sun., Jul 5	In																		In																		
	Out																		Out																		
		1	2	3	4	5	6	7	8	9	10	11	12	15	30	45	A	P		1	2	3	4	5	6	7	8	9	10	11	12	15	30	45	A	P	Absent
Mon., Jul 6	In																		In																		
	Out																		Out																		
Tue., Jul 7	In																		In																		
	Out																		Out																		
Wed., Jul 8	In																		In																		
	Out																		Out																		
Thu., Jul 9	In																		In																		
	Out																		Out																		
Fri., Jul 10	In																		In																		
	Out																		Out																		
Sat., Jul 11	In																		In																		
	Out																		Out																		
Sun., Jul 12	In																		In																		
	Out																		Out																		

I certify these hours of care are correct		I certify these hours of care are correct	
Parent Signature		Provider Signature	

470-4534 Rev(02/09)