Iowa Department of Human Services

CHILD CARE ASSISTANCE BILLING / ATTENDANCE PROVIDER RECORD

Parent:
Child:
Case #:

Billing Period: to

Date	Time In	Time Out	Time In	Time Out	Absent
Mon,					
Tue,					
Wed,					
Thu,					
Fri,					
Sat,					
Sun,					
Mon,					
Tue,					
Wed,					
Thu,					
Fri,					
Sat,					
Sun,					

I certify that this information is true and correct, and that this child care was provided for the sole purpose for which this child was certified. I understand that I may be required to repay any overpayment resulting from false or incorrect claim forms.

Parent's Signature _____ Date _____

Provider's Signature _____ Date _____