

Child Welfare Child Care Invoice for Foster Parents and Relative Caregivers



Foster parent/relative caregiver name: _____ DHS provider no.: _____

Child name: _____ Person ID: _____

Child DOB: _____

Child care provider name: _____

(This must be the provider indicated on the approve Child Welfare Child Care Authorization [CF 0162].)

Dates of service

From: _____ To: _____

A child care reimbursement may be issued for the amount of the payment indicated below or \$375 per month, whichever is less.

Amount paid for child care: \$ _____

Signing this invoice indicates that to the best of your knowledge, the information is true and accurate.

Foster parent or relative caregiver signature

Date

Child care provider signature

Date

Child welfare supervisor

Date

Department use only

Authorization no.: _____

Payment ID: _____	Payment amount: _____
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Orkids: Service category: Child Care for Foster Parents
Service type: Child Care for Foster Parent Reimbursement 0-5
Child Care for Foster Parent Reimbursement 6-12
Child Care for Foster Parent Reimbursement 13-20

Procedure: This form must be scanned into the OR-Kids file cabinet.