

Iowa Department of Human Services
PROMISE JOBS CHILD CARE ATTENDANCE AND INVOICE
1. Billing Period ___ - ___ - ___ **thru** ___ - ___ - ___

2. Return form to: Office Iowa Workforce Development/PROMISE JOBS Worker Address 600 S. Pierce, Mason City, Iowa 50401	3. Agreement Number 4. Provider Name (Print) 5. Provider Address 6. City & State 7. Zip
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8. Parent or Relative	9. Parent or Relative's State ID
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Child # 1					Child # 2					Child # 3				
10. Name:					10. Name:					10. Name:				
11. Age:					11. Age:					11. Age:				
Attendance					Attendance					Attendance				
Date	12. Time In	13. Time Out	14. Units per Day	15. ✓ if Absent	Date	12. Time In	13. Time Out	14. Units per Day	15. ✓ if Absent	Date	12. Time In	13. Time Out	14. Units per Day	15. ✓ if Absent
01	to				01	to				01	to			
02	to				02	to				02	to			
03	to				03	to				03	to			
04	to				04	to				04	to			
05	to				05	to				05	to			
06	to				06	to				06	to			
07	to				07	to				07	to			
08	to				08	to				08	to			
09	to				09	to				09	to			
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27	to				27	to				27	to			
28	to				28	to				28	to			
29	to				29	to				29	to			
30	to				30	to				30	to			
31	to				31	to				31	to			
	16. Total Units	17. Unit Cost	18. Cost for Child			16. Total Units	17. Unit Cost	18. Cost for Child			16. Total Units	17. Unit Cost	18. Cost for Child	
Month 1	X	=		Month 1	X	=		Month 1	X	=		X	=	
Month 2	X	=		Month 2	X	=		Month 2	X	=		X	=	

I certify that the dates and hours of care for each child above are correct.

19. Provider Signature	20. Social Security # or Federal ID #	21. Phone #	22. Date
23. Parent/Relative's Signature		24. Date	

"For local office use only:"

Total Cost for Month One \$	Total Cost for Month Two \$	Date Returned to Provider	Date Corrected Invoice Received
Approval		Date	

General Information

Use this form to bill the Department of Human Services (DHS) for payment of child care services provided for a parent or relative's participation in PROMISE JOBS activities. Contact the PROMISE JOBS worker if you have questions regarding the parent or relative's eligibility for Child Care Assistance.

Providers can choose to bill DHS once every two weeks or monthly. Complete this form after close of business on the last day of the two-week billing period, last day of the month, or the last day that the parent or relative needs child care for participation in PROMISE JOBS activities, whichever applies.

Instructions for Providers

- Billing Period:** Enter the beginning and ending dates of the billing period. For example, enter: 07-01-07 thru 07-31-07.
Submit a separate invoice for each billing period. If billing monthly, submit a separate invoice for each calendar month.
- Return form to:** Skip this field. PROMISE JOBS staff fills it out.
- Agreement Number:** Enter your agreement number from the top, right corner of your Child Care Assistance Provider Agreement. The number is 7 digits.
- Provider Name:** Enter your name or the name of your business as it appears on your Child Care Assistance Provider Agreement.
- Provider Address:** Enter your street address as it appears on your Child Care Assistance Provider Agreement.
- City & State:** Enter your city and state as it appears on your Child Care Assistance Provider Agreement.
- Zip:** Enter your zip code as it appears on your Child Care Assistance Provider Agreement.
- Parent or Relative:** Enter the parent or relative's first and last name unless PROMISE JOBS already filled in.
- Parent or Relative's State ID:** Skip this field. PROMISE JOBS staff fills it out.

Child Columns: Complete the following fields for each child that you are billing DHS for approvable child care during the billing period. Attach additional forms if billing for more than 3 children.

- Name:** Enter the child's first and last name.
- Age:** Enter the child's age.

Attendance Columns: Complete the following fields for each date of approvable child care for the listed child.

- Time In:** Enter the actual beginning time of the child's attendance.
- Time Out:** Enter the actual ending time of the child's attendance.
- Units per Day:** Enter the number of units based on the child's actual attendance. A "unit" is any amount of time up to and including 5 hours of service in a 24-hour day. More than 5 up to 10 hours is 2 units. Refer to your copy of the Notice of Decision: Child Care Assistance issued to the parent or relative for the number of approved child care assistance units for the parent or relative.
- if Absent:** Check this field if billing for hours when the child was absent.
- Total Units:** If all days of service were in the same month, add the number of units and enter in Month 1 line. If days of service were in more than one month, add the number of units for each month and enter the totals in Month 1 and Month 2 lines.
- Unit Cost:** Enter the amount that you are approved to receive for each unit in Month 1 line. If days of service are in more than one month, enter the amount in Month 1 and Month 2 lines. You can find this information on your Child Care Assistance Provider Agreement in the rate section.
- Cost for Child:** Multiply the total units by the unit cost for Month 1, and Month 2 (if applicable).
- Provider Signature:** Sign the form in ink.
- Social Security # or Federal ID #:** Enter your Social Security number or your Federal ID number.
- Phone #:** Enter your phone number.
- Date:** Enter the date you sign the form.
- Parent/Relative's Signature:** PROMISE JOBS parent or relative signs.
- Date:** Enter the date the PROMISE JOBS parent or relative signs the form.

If billing for daily/weekly units that are greater than what is approved on the Notice of Decision for the child, attach a note to explain why.