NIAGARA COUNTY DEPARTMENT OF SOCIAL SERVICES
P.O. BOX 506
Lockport, New York 14095-0506

Approved by

_____
Emp/TA Worker
Signature/Initials

REQUEST FOR PAYMENT OF DAY CARE SERVICES
TO BE COMPLETED BY CHILD CARE PROVIDER

Care Provided
From: Month _____Day_____Year_____ to Month_____Day_____Year_____

Case Name _____ Provider Name _____

Case Number _____ Vendor Number _____

Child's Name _____ Provider Address _____

_____

**Bills must be received by the Agency within 90-days from date of service to be eligible for processing.

ACTUAL DATE OF SERVICE	TIME IN/OUT	TOTAL HOURS PER DAY
	TO	
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FORM #: NPA-8325A
REV. 1/17

ACTUAL DATE OF SERVICE	TIME IN/OUT	TOTAL HOURS PER DAY
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**PROVIDER NOTE: RATES CHARGED TO THE DEPARTMENT CANNOT EXCEED THOSE CHARGED TO THE GENERAL PUBLIC, INCLUDING ANY DISCOUNTS THAT MAY APPLY.
**PLEASE BE ADVISED THAT IT CAN TAKE UP TO SIXTY (60) DAYS FOR PAYMENT TO BE ISSUED; NO INFORMATION WILL BE GIVEN OUT ON THE STATUS OF A SUBMITTED BILL UNTIL 30-DAYS FROM THE DATE IT IS DATE STAMPED IN THE AGENCY AS RECIEVED

BY SIGNING BELOW, I AM CERTIFYING THAT THE INFORMATION ON THIS FORM IS TRUE AND THAT THE CHILD CARE SERVICES LISTED WERE PROVIDED AND BILLED CORRECTLY

_____ _____
CHILD CARE PROVIDER SIGNATURE DATE CLIENT SIGNATURE DATE

*REMINDER: AT THE **END OF EACH MONTH** IT IS THE ***PARENT'S RESPONSIBILITY*** TO REVIEW AND SIGN THE BACK OF THE DAYCARE BILLS ATTESTING TO THE HOURS BEING BILLED FROM THE DAYCARE PROVIDER. IF YOU DO NOT AGREE WITH THE HOURS BEING BILLED, **DO NOT SIGN UNTIL THE DISCREPANCY HAS BEEN CORRECTED**.

THIS SPACE FOR OFFICE USE ONLY

AMOUNT _____ PERIOD COVERED _____TO_____
APPROVED BY:

_____ _____ _____
SIGNATURE OF DSS DAY CARE WORKER DATE TA PAY TYPE