Salt River Pima-Maricopa Indian Community

CCDF Certificate Program Billing Form

Name of Provider: _____ **Month/Year of Service:** _____

Provider Address: _____ **Provider Phone Number:** _____

_____

CHILD CARE SERVICES

Name of Child Receiving Services (Last, First)	*Service Type*	*Monthly Bill*	*Monthly Parent Co-Pay*	*Total Billed to CP**
Total				

Service Type:	
	FT - Full Time
	PT - Part Time
	B/A - Before/After Care

*****Total billed to CP is not guaranteed to match what will be paid to the provider by the Certificate Program.

REGISTRATION FEES

Name of family	*Amount*
Total Monthly Registration Fees	

Total Monthly Charges (add total child care services and total registration fees)

Certification: I CERTIFY that the services listed on this statement were rendered on behalf of the above named persons; "under penalty of perjury" that this claim constitutes the full and complete charge for said services described above; that I will make no further claim for payment of these services; that these services have been provided without discrimination based upon age, race, color, creed, and or national origin; that this statement is subject to Federal and State Audit or Review.

_____ _____

Provider's Signature (the individual completing this form is required to provide their signature and date)

Date

For billing questions call 480-362-2268

_____

Print name of provider signing

Remit to: Scan and email to Lisa.Loya@saltriverschools.org or send by fax to billing at 480-362-2243