Joseph Seeber
Commissioner

Provider Reimbursement

St. Lawrence County CCAP
Department of Social Services
slcdaycareunit@stlawco.gov

6 Judson Street
Canton, New York 13617-1196
Phone 315-379-2285

Client Name: _____ ***Case Number:*** _____

Provider Name: _____

For the Week of: Monday __/__/____ ***Through Sunday*** __/__/____

In the spaces provided below, show the total number of hours child care was provided on each day for each child. If an Absence or Program Closure is being claimed, ***circle the day,*** fill in the time frame ***that is being claimed & indicate Absence or Program Closure.***

Name of the Child		Mon	Tues	Wed	Thur	Fri	Sat	Sun
	Time Frame							
	Total Hours							
	Time Frame							
	Total Hours							
	Time Frame							
	Total Hours							
	Time Frame							
	Total Hours							
	Time Frame							
	Total Hours							
	Time Frame							
	Total Hours							

Provider Certification

I certify that Child Care Services were provided on the specified dates to the herein named client as outlined in the above table. I further certify that I have been registered or certified by the St. Lawrence County Department of Social Services as a Legal Child Care Provider. I understand that any payments made for these day care services will be subject to reconciliation with actual work or training schedules of the named client. If it is determined that an overpayment has been made, the amount of the overpayment will be recouped from a future payment for the client and that it is the client's sole responsibility to pay the provider for services rendered which were not approved for payment by the Department of Social Services. I understand that any false statements made herein are punishable as a Class A Misdemeanor pursuant to Section 210.45 of the Penal Law.

Signed:_____ Dated:_____