

Parent:

CLACKAMAS COMMUNITY COLLEGE
Associated Student Government Childcare Grant
Childcare Provider Invoice

Provider _____ Phone _____
Address _____
City _____ State _____ Zip _____
Provider Number or Social Security Number _____
Name of Parent _____
Parent's Social Security Number _____ Amount of Award _____
Name of Child _____

Please list the dates child care was provided and number of hours. (Example: 01/03/12 - 8 hours)

Date	Hours (Example: 8:00am – 2:00pm = 6 hours)	Daily Total
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Reimbursement Request: _____ X _____ = \$
 Hours/days Hourly/daily Rate **AMOUNT DUE**

Less payment (if any) to provider \$ _____

Net amt to be paid from CCC Childcare Grant Fund \$ _____

I certify that the above information is true, accurate, and complete.

_____ Date
Provider's Signature

When the amount due reaches the amount of award (see award letter), please email this form to: