

Squares must be filled in completely using Capital Letter and Black Ink, without touching the sides.

Begin Date: Must be entered as MM/DD/YYYY, for ex. 01/04/2006. This should be the first day of child care being reported on this invoice.

End Date: Must be entered as MM/DD/YYYY, for ex. 01/17/2006. This should be the last day of child care being reported on this invoice.

Payment code: Three digit number that appears on the family authorization under pay codes.

Provider ID: Type B and PPI's: this is your nine digit Social Security Number.
Center's: this is your assigned nine digit ID number. You will need to add leading zeros to fill in the all blocks in this area.

Parent's Last Name: Insert Parent's last name using all capital letters, as it appears on the authorization

First Initial: Insert Parent's first initial using all capital letters.

Parent's SS number: Insert parent's social security number as it appears on the authorization.

Child's Last Name: Insert Child's Last Name using all capital letters, as it appears on the authorization

Child's First Name: Insert Child's First name using all capital letters, as it appears on the authorization.

Child ID: This is the two digit recipient number listed on the authorization by the child's name.

Delete: Blacken in this circle when a mistake is made in the data on the line or when the line is not needed. Do not mark through a box or use white-out.

Month: Insert month (example: 08 for the month of August, must always be two digits).

Day: Insert Day (example 08 for the 8th day, must always be two digits)

Time In: Insert start time (example 08:00, must always fill in all four boxes)

A/P Insert A for A.M. and P for P.M., must be capital letters

Time Out: Insert end time (example 08:00, must always fill in all four boxes)

2nd Time In/Out: This is for split hours that occur in the same day. (ex: child leaves the provider's home for ½ day school and returns to provider's home for add'l care after school.

Rate Code: Letter plus two digits used to designate the correct amount to be paid for that line. This information is provided by the agency according to your contract. H=hourly
W= full or part time week (ex: H01 means hourly traditional, W02 means either full or part time week non traditional)

ABS Fill in only if the child was absent and was suppose to be present that day. Hours that the child was expected to be there have to be listed on this line.

Activity, etc. Negotiated in contract. Letter plus two digits used to designate the correct amount to be paid for this invoice. (ex. M01 means monthly charge and 01 reflects the amount. Code will be provided by the agency according to your contract.

Parent Signature: Parent signature is required. The invoice cannot be processed for payment without it.

Date: MM/DD/YYYY, (ex. 01/01/2006) This date cannot be prior to the last day of child care being submitted for payment on this invoice.

Provider Signature: Provider signature is required.

Provider Name: Print provider's name or name of Center

Date: MM/DD/YY, (ex. 01/01/2006) This date cannot be prior to the last day of child care.

Please do not fold, stain or write, other than in the areas provided, on this invoice. Doing so may cause the scanning system to reject your invoice slowing down the payment process.

Washington County Child Care Invoice

Submit completed invoices to:

Washington County Dept. of Job and Family Services, Social Services Unit
1115 Gilman Avenue, PO Box 2005 Marietta, OH 45750

Please fill in circles completely and write responses in CAPITAL LETTERS using BLACK INK without touching the sides.

●	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	0	1	2	3	4	5	6	7	8	9
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Begin Date (MM/DD/CCYY) 11 / 01 / 2005	End Date (MM/DD/CCYY) 11 / 12 / 2005	Paycode 321	Provider ID (no dashes) 001122334
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Parent's Last Name SMITH	First Initial R	Parent's Social Security Number 222 44-7789
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Child's Last Name JONES	Child's First Name ALICIA	Child ID 01
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Delete	Month	Day	Time In	A/P	Time Out	A/P	Time In	A/P	Time Out	A/P	Rate Code	Abs
O Del	11	01	12:00	P	04:30	P					W02	O Abs
O Del	11	02	08:00	P	11:30	P					W02	O Abs
O Del	11	03	12:00	P	07:00	P					W02	O Abs
O Del	11	04	12:00	P	04:30	P					W02	● Abs
● Del												O Abs
O Del	11	06	12:00	P	04:30	P					W02	O Abs
O Del	11	08	11:45	A	05:15	P					W02	O Abs
O Del	11	10	07:45	A	04:00	P					W02	O Abs
O Del	11	12	07:45	A	04:30	P					W02	O Abs
● Del												O Abs
● Del												O Abs
● Del												O Abs
● Del												O Abs
● Del												O Abs
● Del												O Abs
● Del												O Abs

SAMPLE

❖ Activity Fee	Transportation	Deposit	Registration	Other Fee
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

I certify that I have received the services indicated in this invoice.

[Signature]

Parent Signature

11 / 16 / 2005
Date (MM/DD/CCYY)

I certify the charges for services shown on this invoice are correct and in accordance with the terms of the agreement. My signature means I understand that the law provides a penalty upon conviction for claiming or accepting payment for services not given.

[Signature]

Provider Signature

[Signature]

Provider Name

11 / 12 / 2005
Date (MM/DD/CCYY)

The Washington County Department of Job and Family Services requires that all monthly invoices for Social Services be turned into the agency for payment no later than 60 days after the last date of services. Failure to do this may result in no payment for the services rendered.

Washington County Child Care Invoice

Submit completed invoices to:

Washington County Dept. of Job and Family Services, Social Services Unit
1115 Gilman Avenue, PO Box 2005 Marietta, OH 45750

Hours

Please fill in circles completely and write responses in CAPITAL LETTERS using BLACK INK without touching the sides.

●	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	0	1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

Begin Date (MM/DD/CCYY) 11/28/2005	End Date (MM/DD/CCYY) 12/16/2005	Paycode 321	Provider ID (no dashes) 001122334
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Parent's Last Name SMITH	First Initial R	Parent's Social Security Number 222-44-7789
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Child's Last Name JONES	Child's First Name ALICIA	Child ID 01
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Delete	Month	Day	Time In	A/P	Time Out	A/P	Time In	A/P	Time Out	A/P	Rate Code	Abs
O Del	11	28	08:00	A	12:00	P	04:10	P	06:30	P	W02	O Abs
O Del	11	30	08:00	A	12:00	P	04:15	P	06:20	P	W02	O Abs
O Del	12	02	07:45	A	06:15	P					W02	O Abs
O Del	12	03	07:50	A	04:05	P					W02	O Abs
● Del												O Abs
O Del	12	05	04:10	P	11:15	P					W02	O Abs
O Del	12	07	04:30	P	11:07	P					W02	O Abs
O Del	12	09	08:00	A	12:00	P	04:10	P	06:05	P	W02	O Abs
O Del	12	10	08:00	A	04:15	P					W02	O Abs
● Del												O Abs
O Del	12	12	04:00	P	12:00	P					W02	O Abs
O Del	12	13	12:01	A	07:45	A					W02	O Abs
O Del	12	14	04:00	P	06:30	P	11:00	P	11:59	P	W02	O Abs
O Del	12	15	12:00	A	12:00	P					W02	O Abs
O Del	12	16	08:00	A	12:00	P	04:10	P	06:30	P	W02	O Abs
● Del												O Abs

❖ Activity Fee	Transportation	Deposit	Registration	Other Fee
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

SAMPLE

I certify that I have received the services indicated in this invoice.

[Signature]

Parent Signature

12/16/2005

Date (MM/DD/CCYY)

I certify the charges for services shown on this invoice are correct and in accordance with the terms of the agreement. My signature means I understand that the law provides a penalty upon conviction for claiming or accepting payment for services not given.

[Signature]

Provider Signature

[Signature]

Provider Name

12/16/2005

Date (MM/DD/CCYY)

The Washington County Department of Job and Family Services requires that all monthly invoices for Social Services be turned into the agency for payment no later than 60 days after the last date of services. Failure to do this may result in no payment for the services rendered.