# SOLANO FAMILY & CHILDREN'S SERVICES

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**NOTE:** THE MERE ACT OF RECEIVING THIS TEMPORARY CHILD CARE ATTENDANCE FORM DOES NOT GUARANTEE REIMBURSEMENT FROM SFCS

## Temporary Child Care Attendance Form (CCAF)

**Please Print All Information In the Spaces Below:**

Child's Name: _____ Month Services Were Provided: _____

Parent's Name: _____ Year Services Were Provided: _____

Provider's Name: _____ Provider's Address: _____

ALL TIMES AND SIGNATURES ON THIS FORM MUST BE IN INK.

*For Variable Schedules – Days without times, Absence, or DNO (Day of Non Operation) indicated, are No Care Days & reimbursement will not be made for those days.*

*PLEASE REMEMBER TO INCLUDE AM OR PM ON IN/OUT TIMES* — *SHADED AREAS ARE FOR CHILDREN WHO GO TO SCHOOL*

| DATE | TIME IN | TIME OUT | TIME IN | TIME OUT | DATE | TIME IN | TIME OUT | TIME IN | TIME OUT |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | 17 | | | | |
| 2 | | | | | 18 | | | | |
| 3 | | | | | 19 | | | | |
| 4 | | | | | 20 | | | | |
| 5 | | | | | 21 | | | | |
| 6 | | | | | 22 | | | | |
| 7 | | | | | 23 | | | | |
| 8 | | | | | 24 | | | | |
| 9 | | | | | 25 | | | | |
| 10 | | | | | 26 | | | | |
| 11 | | | | | 27 | | | | |
| 12 | | | | | 28 | | | | |
| 13 | | | | | 29 | | | | |
| 14 | | | | | 30 | | | | |
| 15 | | | | | 31 | | | | |
| 16 | | | | | A = Absence | DNO = Day of Non Operation | | NC = No Care | |

In completing and signing this form, we (parent and provider) understand that this form is NOT an agreement or contract of any type with Solano Family and Children's Services (SFCS). We understand that this form is only to be used as a temporary means of tracking days and hours of child care. We understand that reimbursements will not be made by SFCS until certain criteria have been met - including, but not limited to, parent and provider eligibility. Reimbursements will only be made by SFCS with valid, current Certificates for Child Care Services, with terms agreed upon between SFCS, the parent, and the provider.

PARENT:

I certify that the hours of attendance (including holidays) as stated above are true and accurate and that child care was necessary for the purpose specified during my last certification of eligibility. I certify that I have reported all changes in my income, employment, training, family size, and all other eligibility/need during the month listed above, to my assigned Family Services Specialist. I further certify under penalty of perjury under the laws of the State of California that the above statements are true and correct to the best of my knowledge.

Parent's FULL Signature: _____ Date Signed: _____

CHILD CARE PROVIDER:

I certify that I provided the child care services stated above. I have claimed ALL child care hours provided by me at the address on file with SFCS, with the understanding that SFCS will ONLY reimburse me for the certified child care hours. I certify that I operated within compliance of all Subsidized Child Care Program Regulations and SFCS Provider Policies (as they apply to my type of care), while providing child care services during the month listed above. I further certify under penalty of perjury under the laws of the State of California that the above statements are true and correct to the best of my knowledge.

Provider's FULL Signature: _____ Date Signed: _____

**PROVIDER'S BILL (Licensed Providers Only – Required for Reimbursement):** Bill According to **Your Own** Fee Schedule.

**You can use the calendar below to Mark (X) days of care to help with calculations.**

| Su | M | T | W | Th | F | Sa | | If You Charge WEEKLY | | If You Charge DAILY or HOURLY | Multiplied by Days or Hrs. | SUBTOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | 1st wk | $ | or | $ | x | = $ |
| | | | | | | | 2nd wk | $ | or | $ | x | = $ |
| | | | | | | | 3rd wk | $ | or | $ | x | = $ |
| | | | | | | | 4th wk | $ | or | $ | x | = $ |
| | | | | | | | 5th wk | $ | or | $ | x | = $ |
| | | | | | | | 6th wk | $ | or | $ | x | = $ |

PRORATE **1st** & **last** weeks (if partial)

**If You Charge MONTHLY Rates ONLY** $

**Annual Registration Fees Due This Month** $

**GRAND TOTAL** $

**FAMILY FEE STATEMENT:** This section must be completed by ALL Providers who have Parents Paying Family Fees.

☐ This is to certify that on _____ (Date Received) I, _____ (Provider's Name) _____ received/collected family fees in the amount of $ _____ for _____ (Month/Year).

☐ This is to certify that I, _____ (Provider's Name) _____ did not receive/collect family fees for the month of _____ (Month/Year)

because (explain): _____