Chugachmiut Child Care Assistance
Billing Report

Provider Name _____ City, State, Zip Code _____ Federal Tax ID or Social Security Number _____

Mailing Address _____ Telephone Number _____ Report Period for Month: _____ Year: _____

Parent Name: _____

Return to: *Chugachmiut - Attn: Taren Klingler*
1840 Bragaw Street, Suite 110
Anchorage, AK 99508

☐ Check Here if Change of Address

C - Child's Name (First & Last) | F - Full time, P -Part time - I - Infant, T-toddler, P - Pre-school age, S - School age

C - Child's Name (First & Last)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total Days Attended P	Total Days Attended F	Age	Total Part Time Amount	Total Full Time Amount		TOTAL*		(Percentage Based) CCCAP % Portion	(Percentage Based) Parent % Portion
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NOTES: _____

Certification Statement:
We certify that the above information is a true and accurate accounting of the child care hours provided this month. We also certify the parent has paid their portion or has made a mutual arrangement to pay the balance.
Each month Provider & Parent Signatures are required for payment.

Provider Signature _____ Date _____

Parent Signature _____ Date _____

***TOTAL should not exceed the authorization amount stated on the child care authorization form. Please note: The Chugachmiut Child Care Assistance Program will only provide assistance while the parent is working or attending training and only for the days the child(ren) actually receive child care. Holidays and other child care center/home closures are not covered by the program. Any such child care charges are the responsibility of the parent to pay. The Parent and the Provider must sign this billing report monthly to ensure the accuracy of hours billed.**