



ASNA CHILD CARE IN AND OUT LOG

FOR OFFICE USE ONLY

PROVIDER'S NAME: _____

PROVIDER'S ADDRESS: _____

PARENT'S NAME: _____

MONTH OF SERVICE: _____

Vendor ID: _____
Invoice #: _____
Invoice Date: _____

ASNA CCDF APPROVAL	
I CERTIFY THAT I REVIEWED THE INVOICE PROVIDED FROM THE CCDF PROVIDER AND APPROVE PAYMENT	
CCDF STAFF INITIAL	DATE

CHILD'S FIRST & LAST NAME	AGE	DATE	TIME IN	TIME OUT	TOTAL TIME	PROVIDER INITIALS	PARENT INITIALS	COMMENTS

PARENT & PROVIDER CERTIFICATION

We certify that the information and times provided on this form is true and correct and that I was engaged in eligible activities during the hours we are billing for. We understand that any time paid for where I am not engaged in eligible activities will be considered fraud and that amount will have to be reimbursed back to ASNA by the provider. We also understand that reporting false time may result in temporary or permanent suspension of services for both parent(s) and provider. We also understand that after submitting a correct and completed timesheet, it may take anywhere from 1 week to 21 days for the provider to receive payment.

Parent's Signature: _____ Provider's Signature: _____

VOLUNTARY FEDERAL TAX WITHOLDING

I would like to withhold taxes from this invoice:
 Yes _____ No _____

Please withhold: 5% _____ 10% _____ 20% _____

Provider Signature: _____