DAY CARE BILLING RECORD

Consumer First Name : ________________________ Last Name : ___________________________

Family Member Name : ____

Address: ____
(street) (city) (state) (zip code)

Phone# : (   )_______________________________ Client UCI # __________________________

Vendor # ____________________________________ Service Month _____________ (Year) _____

Date of Service (MM/DD)	Address Where Services were given – if different than above.	Name of Worker, Agency, or Facility Used	Start Time	End Time	# of Hours Worked	Amount Billed ($)
			Total Hours and Amount billed			

Vendor Signature ____ Date ________________________