State of Illinois
Department of Human Services - Bureau of Child Care and Development

REQUEST FOR REIMBURSEMENT

Child Care Case Number: ______________________ Date: ____________

Client Name and Address:

List a telephone number where you can be reached during the day

Home: ____________ Work: ____________

In order to be reimbursed for CHILD CARE payments, this form must be completed and signed by the client and provider. Return to the address listed below.

Client Social Security Number: ____________

Month of Service: (Use a separate form for each month) ____________

Name of Child	Number of Days Attended During Month		Amount Client Paid to the Provider for the Month	CCR&R USE ONLY: Rate		CCR&R USE ONLY: Amount DHS Will Pay
	Full	Part		Full	Part	
					Parent Co-Payment	
					Total	

Client Certification:

I certify that the child care services listed above were received and that I have paid the provider and have not been reimbursed. I understand giving false information or failure to provide correct information can result in referral for prosecution for fraud.

Client's Signature: ______________________ Date: ____________

Provider Cerification:

Provider's Name: ______________________ Provider's Social Security or FEIN: ____________

- ☐ Licensed Center (760)
- ☐ Licensed Exempt Center (761)
- ☐ Licensed Home (762)
- ☐ Licensed Group Home (763)
- ☐ Licensed Exempt Home (764)
- ☐ Relative in Relative's Home (765)
- ☐ Non-Relative in the Child's Home (766)
- ☐ Relative in Child's Home (767)

I certify that the child care services listed above were provided and that payment has been reeived. I understand giving false informaiton or failure to provide correct information can result in referral for presecution for fraud.

Provider's Signature: ______________________ Date: ____________