

MAIL TO: SC Child Care Council PO Box 186, Ferndale, NY 12734		Sullivan County Dept. of Health and Family Services	
Vendor Name:		PO Box 231, Liberty, NY 12754	
Vendor Phone Number:		Case#: PA or SUBSIDY	Client Name:
Vendor MAILING Address:		Client PHYSICAL Address:	
		Street:	City: State: Zip:
Vendor #:	Child's Name:	Child's DOB:	# of Children In Family:
	Co-Pay Paid? Yes _____ No _____	Child's Current Age:	_____ Foster Care

EXPIRATION DATE: Payments *may not* be processed if received **60 days** after last date of care shown below. Care provided prior to this pay period? _____ Yes _____ No

Date	Day of the Week	Begin Time	End Time	Notes (ex: sick day – snow day)
/ 16 /		AM PM	AM PM	
/ 17 /		AM PM	AM PM	
/ 18 /		AM PM	AM PM	
/ 19 /		AM PM	AM PM	
/ 20 /		AM PM	AM PM	
/ 21 /		AM PM	AM PM	
/ 22 /		AM PM	AM PM	
/ 23 /		AM PM	AM PM	
/ 24 /		AM PM	AM PM	
/ 25 /		AM PM	AM PM	
/ 26 /		AM PM	AM PM	
/ 27 /		AM PM	AM PM	
/ 28 /		AM PM	AM PM	
/ 29 /		AM PM	AM PM	
/ 30 /		AM PM	AM PM	
/ 31 /		AM PM	AM PM	

Client/Recipient: I the undersigned certify that the above listed goods and services were received by me on (dated _____) in a satisfactory manner and in serviceable condition.

Signature (BLUE INK ONLY): _____ Date: _____

Vendor Certification: I the undersigned, hereby certify that the items shown above are correct and that the materials and services therein have actually been furnished or performed by me and that no part of the claim has been paid or satisfied and that there has been compliance with the Title VI of the Federal Civil Rights Act of 1964 in furnishing these supplies and services.

Signature (BLUE INK ONLY): _____ Date: _____

Office Use Only	
Total	
Recommended By:	Date:
Authorized By:	Date:
Audited By:	Date:

