

Request for Payment of Day Care Services remitted to Lucas County Children Services

Child Name		Payment Designation by Age
Child DOB (MM/DD/YYYY)	Age	



Provider Name	Phone Number	Star Step Up	Type B Day Care Home
Address	Fax Number	Additional Bonuses	
Contact Person	Email	Co-pay Child	Co-pay total

Billing Period Start Date	Billing Period End Date	Absent Days	Total cost of service
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Enter Sunday Begin Date: _____ (MM/DD/YYYY) Last Date of Service (if applicable) _____

Day of the Week	Date	Time IN	Time OUT	Time IN	Time OUT	Daily Total	Type of Billing Rate
Sunday							
Monday							
Tuesday							Cost
Wednesday							
Thursday							Total Weekly Hours
Friday							Hours
Saturday							
Enter Sunday Begin Date: _____ (MM/DD/YYYY)						Daily Total	Type of Billing Rate
Sunday							
Monday							
Tuesday							Cost
Wednesday							
Thursday							Total Weekly Hours
Friday							Hours
Saturday							
Enter Sunday Begin Date: _____ (MM/DD/YYYY)						Daily Total	Type of Billing Rate
Sunday							
Monday							
Tuesday							Cost
Wednesday							
Thursday							Total Weekly Hours
Friday							Hours
Saturday							
Enter Sunday Begin Date: _____ (MM/DD/YYYY)						Daily Total	Type of Billing Rate
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Monday							
Tuesday							Cost
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