STATE OF NEW HAMPSHIRE
Department of Health and Human Services
Division for Children, Youth and Families

Form 2500
March 2009

CHILD CARE PAYMENT REQUEST INVOICE

Type or print all information. Please read the instructions before you begin. Be sure to sign your name at the bottom of the form.

PROVIDER NAME AND PHYSICAL ADDRESS:

Name: _____

Address: _____

_____

Phone: _____

PARENT NAME AND PHYSICAL ADDRESS:

Name: _____

Address: _____

_____

Phone: _____

CHILD'S NAME AND ID NUMBER: (only one child per form)

Last: _____ First: _____

Child's RID # | | | | | | | | | | | |

ENTER DATE (MONTH/DAY/YEAR)	OCCURRENCE	ARRIVE TIME	AM	PM	DEPART TIME	AM	PM	PRESENT	ABSENT
Monday / /	1		☐	☐		☐	☐	☐	☐
	2		☐	☐		☐	☐	☐	☐
	3		☐	☐		☐	☐	☐	☐
Tuesday / /	1		☐	☐		☐	☐	☐	☐
	2		☐	☐		☐	☐	☐	☐
	3		☐	☐		☐	☐	☐	☐
Wednesday / /	1		☐	☐		☐	☐	☐	☐
	2		☐	☐		☐	☐	☐	☐
	3		☐	☐		☐	☐	☐	☐
Thursday / /	1		☐	☐		☐	☐	☐	☐
	2		☐	☐		☐	☐	☐	☐
	3		☐	☐		☐	☐	☐	☐
Friday / /	1		☐	☐		☐	☐	☐	☐
	2		☐	☐		☐	☐	☐	☐
	3		☐	☐		☐	☐	☐	☐
Saturday / /	1		☐	☐		☐	☐	☐	☐
	2		☐	☐		☐	☐	☐	☐
	3		☐	☐		☐	☐	☐	☐
Sunday / /	1		☐	☐		☐	☐	☐	☐
	2		☐	☐		☐	☐	☐	☐
	3		☐	☐		☐	☐	☐	☐

Provider Service Code: | | |

Actual Amount Charged for this WEEK $ | | |

Payment is requested for the child care services listed above. It is understood that payment will only be made for services actually received. No extra costs or fees have been listed for the days this child was not in child care. It is understood that payment will not be made if the person providing the child care lives in the child's household, is a parent of the child or does not meet State license requirements.

I certify that I have read and understood the above statement and certify that the information on this form is true and accurate.

Child Care Provider's Signature _____ Child Care Provider's Resource ID Number _____ Date _____

The parent must be engaged in an authorized and approved activity such as employment, training or job search.
I certify that I was participating in an approved activity for the hours indicated on this form.

Parent/Guardian's Signature _____ Parent/Guardian's Social Security Number - *OPTIONAL* _____ Date _____

PD 09-05

Print Save

INSTRUCTIONS FOR CHILD CARE PAYMENT REQUEST INVOICE

The individual who will be receiving payment from the Department of Health & Human Services must complete this invoice. Complete and submit a separate invoice for each child weekly. For payment to be made, the invoice must be completed correctly and be submitted no later than **90 days** after the delivery of the service. Incomplete, incorrect or illegible invoices will be returned, and payment will be delayed or denied.

PROVIDER NAME AND PHYSICAL ADDRESS

Fill in the provider's first name, last name and physical address. Use the name to whom the check will be issued.

PARENT NAME AND PHYSICAL ADDRESS

Fill in the parent's first name, last name and physical address. Do not include PO boxes.

CHILD'S NAME AND ID NUMBER

Fill in the last name and first name of the child for whom services are being billed on this form and the child's recipient identification number (RID) as it appears on the child's Notice of Decision. If the RID number is less than 11 digits, leave the last box blank.

Date

Enter each date the child was scheduled to attend. Enter the month, day and year. Example: 01/15/09. Monday is the beginning of the billing week. You cannot overlap weeks. For example: If you provided care from Sunday to Friday you would need to complete two separate billing invoices. Sunday would be billed on one form and Monday through Friday would be billed on a separate form.

Occurrence

Enter the arrival and departure time up to three times in one day. If the child arrived and departed more than once you must indicate each arrival and departure time for each occurrence. The following is an example of one day when the child arrived and departed multiple times.

Ex:	Child arrived at 8:01 am and departed at 11:35 am	(this would be occurrence 1)
	Child returned at 1:15 pm and departed again at 3:25 pm	(this would be occurrence 2)
	Child returned at 4:11 pm and departed at 6:10 pm	(this would be occurrence 3)

Arrival Time/Departure Time

Enter the exact hour and minute the child arrived for each occurrence. Enter the exact hour and minute the child departed for each occurrence.

AM & PM

Indicate morning (AM) or afternoon/evening (PM) for each occurrence.

P (Present) / A (Absent)

Indicate P (present) if the child was in attendance for each occurrence. Indicate A (absent) if the child was scheduled to attend and did not attend.
If the child was absent and was scheduled to attend, indicate the scheduled arrival and departure time for the child and an A for absent.

PROVIDER SERVICE CODE

Select the provider service code below that best describes what type of provider you are:
31 – Licensed Center
32 – License-Exempt Family/Friend/Neighbor
33 – Licensed Family Child Care
34 – License-Exempt Center

ACTUAL AMOUNT CHARGED

In the box marked "Actual Amount Charged for this Week", enter the amount actually being charged by the provider for the care of this child for the week. The amount you charge should be decided without regard to the amount DHHS will reimburse you. Indicate the amount in dollars and cents. For example: $50 must be entered as $50.00.
If the parent/guardian works on a major holiday, make a notation in the space next to the date indicating where the parent worked. Example: "Worked at Shaws"
Major Holidays include July 4, Thanksgiving, Christmas, New Year's Day, etc.

In order for the Department to pay a child care provider; the signature of the parent/guardian and the signature and Resource ID Number of the provider must appear on this invoice. By Federal law the parent/guardian's social security number cannot be required as a condition of receiving child care scholarship.

DISTRIBUTION

Mail this form to: NH Department of Health & Human Services, Att: Data Management Unit, PO Box 2000, Concord, NH 03302-2000.
Keep a copy for the child care provider's records. Provide a copy for the parent's records.