



REQUEST FOR REIMBURSEMENT

CITIZEN POTAWATOMI NATION CCDF CHILD CARE PROGRAM
1601S.GORDONCOOPERDR.SHAWNNEOK.74801 (405)878-4861or(405)695-5598



Please Return Form via e-mail to ccdf@potawatomi.org

Family Name: _____ Provider/Facility: _____

Child's Name: _____ Pay Period Date: From _____ To _____

I hereby request payment for the following days:

Day	Date	Time In	Time Out	# of Hours
Monday	1	8:00AM	5:00PM	9.00
Saturday	2	8:00AM	5:00PM	9.00
	3	8:00AM	5:00PM	9.00
	4	8:00AM	5:00PM	9.00
	5	8:00AM	5:00PM	9.00
	6	8:00AM	5:00PM	9.00
	7	8:00AM	5:00PM	9.00
	8	8:00AM	5:00PM	9.00
	9	8:00AM	5:00PM	9.00
	10	8:00AM	5:00PM	9.00
	11	8:00AM	5:00PM	9.00
	12	8:00AM	5:00PM	9.00
	13	8:00AM	5:00PM	9.00
	14	8:00AM	5:00PM	9.00
	15	8:00AM	5:00PM	9.00
	16	12:00PM	5:00PM	5.00

Day	Date	Time In	Time Out	# of Hours
	17	8:00AM	5:00PM	9.00
	18	8:00AM	5:00PM	9.00
	19	8:00AM	5:00PM	9.00
	20	8:00AM	5:00PM	9.00
	21	8:00AM	5:00PM	9.00
	22	8:00AM	5:00PM	9.00
	23	8:00AM	5:00PM	9.00
	24	8:00AM	5:00PM	9.00
	25	8:00AM	5:00PM	9.00
	26	8:00AM	5:00PM	9.00
	27	8:00AM	5:00PM	9.00
	28	8:00AM	5:00PM	9.00
	29	8:00AM	5:00PM	9.00
	30	8:00AM	5:00PM	9.00
	31	8:00AM	5:00PM	9.00

Day(s) 20 x \$ 15.00 Per Day = \$ 375.00

Absent Day(s) 5

Total \$ 375.00

+ Other Charges \$ 0.00

CPN Payment: \$ 375.00

I hereby certify that the rates and attendance shown above are accurate. I also understand that providing false information may result in termination of services, as well as prosecution.

Parent _____

Date _____

Provider _____

Date _____