



Bristol Bay Native Association
 Child Care Development Funding (CCDF)
 P.O. Box 310, Dillingham, AK 99576
 Phone: 907-842-4059 or 1-800-478-4059
 Fax: 907-842-2338 Email: CDDadmin@bbna.com

Bi-Weekly Child Care Provider Request for Payment

Child's Full Name: _____

Parent/Client Full Name: _____

(NOTE): Requests are due on Monday by noon. Checks will be available on Friday by noon.

This portion is to be completed by the BBNA CCDF Child Care Provider:

Provider's Business Name: _____
 or Provider's Full Name: _____
 Dates of Care From: _____ To: _____ Year: _____

NOTE: Write the number of hours the child was in your care, under the appropriate day.

DATE:	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total Hours
HOURS WORKED								

DATE:	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total Hours
HOURS WORKED								

As a BBNA approved Child Care Provider with BBNA Child Care Development Funding, I certify that the listed hours of care for the child listed above are true and accurate. By signing this request of payment, I am certifying that I have provided care for the child named above, during the days/hours listed. I understand that providing inaccurate information is **FRAUD**.

Provider Signature _____ Date _____

I agree with the information provided by the childcare provider and would like BBNA CCDF to pay for the days listed above.

Parent/CCDF Client Signature _____ Date _____

Office Use Only:	0-12 Months old \$5.00/hour \$40 Full day/ \$20 Half day	13-48 Months old \$4.50/hour \$36 Full day/ \$18 Half day	4-12 Years old \$4.00/hour \$32 Full day/ \$16 Half day
Approved Relative Hours _____	= Rate of Pay: _____/hour Amount Due Provider: \$ _____		
Approved Lic. Provider: Rate Full \$ _____	* _____ days= _____ Rate Half \$ _____ * _____ days= _____		
Amount Due Provider: \$ _____			
BBNA CCDF Will Pay: _____ % = \$ _____	Parent Co-Pay: _____ % = \$ _____		
UNAPPROVED HOURS: _____	= Rate of Pay _____/Hours Total Parent Owes \$ _____		

Date Received By BBNA CCDF