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

Child Development Department

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								0

DATE:	**Mon**	**Tue**	**Wed**	**Thur**	**Fri**	**Sat**	**Sun**	**Total Hours**
HOURS WORKED								0

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