



TRIBAL TANF MONTHLY CHILD CARE TIME SHEET



Case Name: _____ Child's Name: _____ Age: _____ Birth date: _____

Provider's Name: _____ Relation to Child: _____ Phone: _____

Provider's Mailing Address: _____

Month	Day of the Week	Time child is dropped off at child care	Time child is picked up from child care	Time child is dropped off at child care	Time child is picked up from child care	Child School Start – End Time	OFFICE USE ONLY Total Child Care Hours For Day
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							

OFFICE USE ONLY	RATE: \$ _____ PER <input type="checkbox"/> HOUR <input type="checkbox"/> DAY <input type="checkbox"/> WEEK <input type="checkbox"/> MONTH	X	TOTAL:	=	TOTAL AMT TO BE PAID: \$ _____	TO: PROVIDER	Eligibility Approval: ✗	Date:
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I certify that the rate and attendance shown are accurate. I also understand that providing false information may result in termination of all benefits. I (Parent / Provider) certify that child care was provided for the child listed above. I (Parent / Provider) understand that child care will not be processed for payment until the (Parent / Provider) has completed all the requested Tribal TANF paperwork. I (Parent / Provider) further understand that any incomplete child care forms will not be processed and will be returned to the participant for correction. I (Parent / Provider) acknowledge that once all required paper work has been submitted completed and correct to the Tribal TANF Eligibility Specialist, child care payment will be mailed via regular mail within 20 business days to the provider. **I (Parent/Provider) will not receive nor do I expect to receive child care assistance for this month from any other organization or program, such as CIMC, Voc. Rehab. Etc.**

Parent Signature ✗ _____

Date: _____

Provider Signature ✗ _____

Date: _____