State of Illinois
Department of Human Services - Bureau of Child Care and Development

REQUEST FOR REIMBURSEMENT

Child Care Case Number: _____ Date: _____

Client Name and Address:

List a telephone number where you can be reached during the day

Home: _____ Work: _____

Return to:

In order to be reimbursed for CHILD CARE payments, this form must be completed and signed by the client and provider. Return to the address listed above right.

Client Social Security Number: _____

Month of Service: (Use a separate form for each month) _____

				CCR&R USE ONLY		
Name of Child	Number of Days Attended During Month		Amount Client Paid to the Provider for the Month	Rate		Amount DHS Will Pay
	Full	Part		Full	Part	
					Parent Co-Payment	
					Total	

Client Certification:

I certify that the child care services listed above were received and that I have paid the provider and have not been reimbursed. I understand giving false information or failure to provide correct information can result in referral for prosecution for fraud.

Client's Signature: _____ Date: _____

Provider Certification:

Provider's Name: _____ Provider's Social Security or FEIN: _____

- ☐ Licensed Center (760)
- ☐ Licensed Exempt Center (761)
- ☐ Licensed Home (762)
- ☐ Licensed Group Home (763)
- ☐ Licensed Exempt Home (764)
- ☐ Relative in Relative's Home (765)
- ☐ Non-Relative in the Child's Home (766)
- ☐ Relative in Child's Home (767)

I certify that the child care services listed above were provided and that payment has been received. I understand giving false information or failure to provide correct information can result in referral for prosecution for fraud.

Provider's Signature: _____ Date: _____