



Substitute Parental/Supplemental Child Care Statement of Services Rendered

Employer-Recipient Case Identification Number: _____ Employer-Recipient Case Name: _____
Category Local Office Group Basic Last First Initial

Employee SSN: _____ Employee Name: _____
Last First MI

Employee Address: _____

Dates of Service: Month Day Year through Month Day Year Employee Date of Birth: Month Day Year

Are you now receiving public assistance? Yes No Is this the first statement you have submitted as a child care employee of this employer-recipient? Yes No

Complete line and multiply the number of work units by the rate to arrive at the total charges for each type care listed.

I performed:

Supplemental Child Care _____ Hours at _____ per hour Total Charges: _____
 Substitute Parental Care _____ Days at _____ per day

If daily rate is used, indicate number of hours worked per day: _____ Note: Social Security Tax will be deducted from the check you receive

Are you a relative of the Employer-Recipient? Yes No If relative, what is your relationship? _____

I certify that the services described in this vendor-payment claim were rendered to the Employer-Recipient named herein, pursuant to my employment agreement with such Recipient; that such services were provided according to Illinois Law and to the rules and policy of the Department of Human Services; that payment has not been received; that I will retain all records as necessary to disclose fully the services provided pursuant to such agreement; and that the above information is true, accurate and complete. I have read, understand, and agree to the program information on the reverse side of this form. I understand that payment of this claim will be from benefits derived from Federal and/or State Funds, and that any false claims, statements, documents, or concealment of a material fact may be prosecuted under applicable Federal or State Laws.

Employee Signature: _____ Date: _____

Completion mandatory, 305 ILCS Public Assistance Code, penalty non-payment
EMPLOYER-RECIPIENT STATEMENT - To Be Signed By Employer If Above Information Is Correct. The service described herein was received by me. I hereby designate the Department posting payment to my above named employee an agent for the purpose of doing all that is required of myself as employer pursuant to section 3504 I.R.C. and Illinois law. This designation is not applicable if payee is a private firm or agency employee.

Employer-Recipient Signature: _____ Date: _____

Employer-Recipient Address: _____

Remarks: _____ For Special Projects Office Approvals:
Approved: _____
Special Projects Worker: _____
Supervisor: _____ Date: _____