FOSTER CARE DAYCARE/BABYSITTING
MONTHLY REMITTANCE

FOSTER PARENT: ______________________________ MONTH: ____________________________

VENDOR ID #: ______________________________ FAMILY DAYCARE: __________________

CHILD'S NAME: ______________________________ PRIVATE HOME: ____________________

PROVIDER'S NAME: ______________________________ DAYCARE CENTER: __________________

ACTUAL COST PER DAY/CHILD: ______________________ FULL TIME: ________________________

SCHOOL AGE: ______________________

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
# HRS______	# HRS______	# HRS______	# HRS______	# HRS______	# HRS______	# HRS______
# HRS______	# HRS______	# HRS______	# HRS______	# HRS______	# HRS______	# HRS______
# HRS______	# HRS______	# HRS______	# HRS______	# HRS______	# HRS______	# HRS______
# HRS______	# HRS______	# HRS______	# HRS______	# HRS______	# HRS______	# HRS______
# HRS______	# HRS______	# HRS______	# HRS______	# HRS______	# HRS______	# HRS______

MAIL TO: FOSTER CARE ACCOUNTING
ATTN: B ATTN: CASEY 435-2946
4TH FLOOR CIVIC CENTER
421 MONTGOMERY STREET
SYRACUSE, NY 13202

Signature: ____

Please remit for reimbursement within 90 days of rendering the services or 30 days of the case closing, whichever occurs first, to ensure proper processing.