

## 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 _____
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# HRS _____	# HRS _____	# HRS _____	# HRS _____	# HRS _____	# HRS _____	# HRS _____
# HRS _____	# HRS _____	# HRS _____	# HRS _____	# HRS _____	# HRS _____	# HRS _____

MAIL TO: FOSTER CARE ACCOUNTING  
 ATTN: ATTN: CASEY 435-2946  
 15TH FLOOR CIVIC CENTER  
 421 MONTGOMERY STREET  
 SYRACUSE, NY 13202

or EMAIL: [casey.steinberg@dfa.state.ny.us](mailto:casey.steinberg@dfa.state.ny.us)

**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.