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: CASEY (315) 435-2946
15TH FLOOR CIVIC CENTER
421 MONTGOMERY STREET
SYRACUSE, NY 13202
or email: fostercare@ongov.net

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.