The Resource Connection

Engaging Families ▪ Empowering Communities ▪ Enriching Lives

8085 Highway 26, Suite G, Mokelumne Hill, CA 95245 - (877) 944 - 9911

Initial: ____________________

Review: ___________________

Final: ______________________

ALTERNATIVE PAYMENT PROGRAM

CHILD CARE ATTENDANCE FORM

PRINT PROVIDER'S FULL NAME	PRINT CHILD'S FULL NAME
PROVIDER'S MAILING ADDRES	PRINT PARENT'S FULL NMAE
	PARENT'S MAILING ADDRESS
PROVIDER'S PHONE NUMBER	PARENT'S PHONE NUMBER FOR MONTH/YEAR
PROVIDER'S EMAIL ADDRESS	PARENT'S EMAIL ADDRESS

DATE	ACTUAL TIME IN	SPLIT SCHEDULE		ACTUAL TIME OUT	ABSENCE CODE C/A	HOURS USED	OFFICE USE ONLY
		OUT	IN				
1	AM PM	AM PM	AM PM	AM PM			1
2	AM PM	AM PM	AM PM	AM PM			2
3	AM PM	AM PM	AM PM	AM PM			3
4	AM PM	AM PM	AM PM	AM PM			4
5	AM PM	AM PM	AM PM	AM PM			5
6	AM PM	AM PM	AM PM	AM PM			6
7	AM PM	AM PM	AM PM	AM PM			7
8	AM PM	AM PM	AM PM	AM PM			8
9	AM PM	AM PM	AM PM	AM PM			9
10	AM PM	AM PM	AM PM	AM PM			10
11	AM PM	AM PM	AM PM	AM PM			11
12	AM PM	AM PM	AM PM	AM PM			12
13	AM PM	AM PM	AM PM	AM PM			13
14	AM PM	AM PM	AM PM	AM PM			14
15	AM PM	AM PM	AM PM	AM PM			15
16	AM PM	AM PM	AM PM	AM PM			16
17	AM PM	AM PM	AM PM	AM PM			17
18	AM PM	AM PM	AM PM	AM PM			18
19	AM PM	AM PM	AM PM	AM PM			19
20	AM PM	AM PM	AM PM	AM PM			20
21	AM PM	AM PM	AM PM	AM PM			21
22	AM PM	AM PM	AM PM	AM PM			22
23	AM PM	AM PM	AM PM	AM PM			23
24	AM PM	AM PM	AM PM	AM PM			24
25	AM PM	AM PM	AM PM	AM PM			25
26	AM PM	AM PM	AM PM	AM PM			26
27	AM PM	AM PM	AM PM	AM PM			27
28	AM PM	AM PM	AM PM	AM PM			28
29	AM PM	AM PM	AM PM	AM PM			29
30	AM PM	AM PM	AM PM	AM PM			30
31	AM PM	AM PM	AM PM	AM PM			31
					TOTAL:		

I. Attendance Form Policies and Procedures

Reimbursement will not be released until a correct and completed Attendance Form is received.

1. Fill out one Attendance Form per child (**no copies or faxes are accepted**).
2. Parents must fill the time in and the time out daily with exact actual times (**no rounding off**).
3. **OTHER REASON CODES** - Each day the child does not use care as scheduled, enter one of the codes listed below in the "Code Column" box on the calendar side.

C	Provider closed	Provider was closed or unavailable to provide care for all or part of a schedule day of care. Providers are limited to 10 closure days per fiscal year (July 1st – June 30th)
A	Absent	Illness of child, parent/guardian, or sibling, appointment of child, or parent/guardian (doctor, dentist, mental health, social services, welfare, education, special education services, counseling or therapy), court ordered visitation for time spent with a parent or relative, family emergency for unplanned situations (court appearance, death, accident, hospitalization of a family member, no transportation).
Excessive absences (out of care 50% or more of certified hours) or abandonment of care (no show or contact) may be cause for a family to be disenrolled from the program.		

4. The provider must indicate below in the Provider Billing section the total amount of Family Fees that were collected for the month of care.
   - The Family Fee is paid directly to the provider
5. Providers: Please remember to contact The Resource Connection when a child has been absent for three or more consecutive days.
6. The parent is financially liable for any unauthorized use of care.
7. Both the parent and provider must sign the acknowledgement below at the end of the month in order for reimbursement to be processed.
8. Reimbursement will be made as follows:
   - Attendance Forms received by the 5th of the month will be processed and paid on the 20th of the month.
   - Attendance Forms received after the 5th of the month may be processed and paid on the 20th of the following month. With the exception for the month of June, the end of the fiscal year, when all Attendance Forms must be submitted by July 5th.
   - Attendance Forms received later than 30 days after the month of services rendered may not be reimbursable.

II. Parent Acknowledgement

I affirm under penalty of perjury that this Attendance Form is true and correct and the Family Fee, if applicable, has been paid for this month of care.

Parent Signature: ______________________________ Date: ____________

III. Provider Acknowledgement

1. I certify that the days of enrollment reported are correct and that a Family Fee of $ ______________ has been collected by me, the provider for the month of care on ________________ (date).
2. I understand that I am an Independent Contractor and I am not an employee of The Resource Connection and I affirm under penalty of perjury that this Attendance Form is true and correct.
3. I understand that family fees are due by the 1st of the month for which the child care fees are assessed. I further understand that I must notify The Resource Connection by the 5th of the month if family fees have not been paid.

Provider Signature: ______________________________ Date: ____________

FOR OFFICE USE ONLY

○ CAPP ○ C3AP
○ C2AP ○ CDSS

	$
	$
	$
Total Amount Calculated	$
Reg. Fee Reimbursement	$
Less Family Fee: P/T F/T	$ - < >
Total Amount Reimbursed	$

PROVIDER BILLING:

	# of units	x Rate	Total
HOURS			
DAYS			
WEEKS			
MONTH			
PROVIDER'S FEE BILLED			$
REGISTRATION FEE BILLED			$
FAMILY FEE COLLECTED			$ - < >
TOTAL AMOUNT BILLED			$