Circle One: Adult DLW IS OS DWG Other: ___________________________

(To be filled out by WAPDD Staff)

Child Care Invoice

Western Arkansas Planning and Development District

1109 South 16th Street Fort Smith, AR 72901

Phone: (479) 785-2651 Fax: (479) 785-1964

______________________________ ______________________________

Childcare Center Telephone Number

____

Address City State Zip

Period Covered Start	End	Parent/Guardian's Name	Child's Name	Rate of Days or Weeks (Circle One)	X	Number of Days or Weeks (Circle One)	=	Total Charges
				$	X		=	$
				$	X		=	$
				$	X		=	$
				$	X		=	$
				$	X		=	$

Total Invoice $ ____________

For payment, see the reverse side or attached pay schedule.

Approved Amt. to be paid: $ ____________

(To be filled out by WAPDD Staff)

I hereby certify that the charges listed above represent a true and accurate account for services rendered. Any amount WAPDD has not agreed to pay is hereby my responsibility to request payment from the parent listed above.

I certify that the invoice has been reviewed, that the parent named herein is enrolled in WIOA Title I-B approved activities, and that the child(ren) named herein are attending the daycare center as specified:

______________________________ ______________________________

Childcare Center's Authorized Signature Date

WAPDD Staff Date

Updated 6/2021