

## CHILD CARE WORKER MONTHLY TIME SHEET

|                                   |                                     |
|-----------------------------------|-------------------------------------|
| Family Member Vendor Name         | Vendor Number                       |
| Consumer's Name                   | Consumer's Identifier Number (UCI#) |
| Childcare Site Address            |                                     |
| Employee's Name                   | Employee's Address                  |
| Employee's Social Security Number | Employee's Phone Number             |
| Employee's Signature              | Employee's Age                      |

| Date          | Start Time | End Time | No. Of Hours | *Rate/Hour | Total/Day |
|---------------|------------|----------|--------------|------------|-----------|
|               |            |          |              | \$8.57     | \$        |
|               |            |          |              | \$8.57     | \$        |
|               |            |          |              | \$8.57     | \$        |
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|               |            |          |              | \$8.57     | \$        |
|               |            |          |              | \$8.57     | \$        |
|               |            |          |              | \$8.57     | \$        |
|               |            |          |              | \$8.57     | \$        |
| Monthly Total |            |          |              |            | \$        |

I CERTIFY THAT THE EMPLOYEE SIGNING ABOVE WAS SELECTED, MONITORED AND ASSIGNED ALL DUTIES, SOLELY BY ME. I FURTHER CERTIFY THAT THE HOURS AND WAGES SHOWN ABOVE ARE CORRECT, AND THAT THE EMPLOYEE PROVIDED ONLY NON-MEDICAL CHILDCARE IN MY HOME AND THAT I WILL RETAIN EVIDENCE (I.E. CANCELLED CHECKS) OF PAYMENT FOR AUDIT PURPOSES.

|                                |      |
|--------------------------------|------|
| Family Member Vendor Signature | Date |
|--------------------------------|------|

**PLEASE RETURN THIS FORM ALONG WITH YOUR MONTHLY BILLING TO: RCEB, Airport Center, 7677 Oakport Street, Suite 300, Oakland, CA 94621**

**YOU MAY COPY THIS TIME SHEET FOR YOUR USE IN BILLING THE REGIONAL CENTER. THIS WILL AVOID DELAYS IN RECEIVING YOUR REIMBURSEMENT SHOULD YOU RUN OUT OF SHEETS AND HAVE TO WAIT FOR MORE TO BE MAILED TO YOU. THANK YOU.**

## INSTRUCTIONS FOR COMPLETING CHILD CARE MONTHLY TIME SHEETS

This form is to be completed by you and your childcare worker. You must submit this form, along with the provider of care claim form.

**Family Member Vendor Name:** Print your full name.

**Consumer Identifier Number (UCI#):** This number is the Consumer ID# included on the Authorization to Purchase Services form. Indicate the number.

**Vendor Number:** This number is included on the Authorization to Purchase Services form. Indicate the number.

**Consumer's Name:** Print the consumer's name.

**Childcare Site Address:** Print the address.

**Employee's Name:** Print the employee's name.

**Employee's Age:** Indicate the employee's age.

**Employee's Phone Number:** Indicate the employee's phone number.

**Employee's Social Security Number:** Indicate the employee's social security number.

**Employee's Signature:** Employee must sign full name. Complete the form for a one-month period only. Please use a separate billing form for each childcare worker.

**Date:** Indicate each date service was provided.

**Start time/End time:** Indicate the time period during which service was provided.

**Number of Hours:** For each date service was provided, indicate the number of hours.

**Total/Day:** Number of hours X \$8.57 = Total/Day.

**Monthly Total:** Indicate the sum of the Total/Day column.

**Family Member Vendor Signature:** Sign your full name to certify that the conditions addressed in the paragraph above your signature are correct.

**Date:** Indicate the date you signed the form.