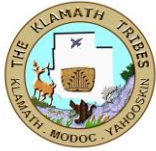


Invoice # _____

Co-Pay: _____

Klamath Tribes Childcare Program
P.O. Box 436
Chiloquin, Oregon 97624
Phone: (541) 783-0804
Fax: (541) 783-2512



Child Care Payment Request

Client's Number: _____

Month Care Provided: _____

Program: _____
Month: _____
Maximum Payment Authorized \$ _____
Worker's Signature: 541-783-0804
Payment has been made to the provider for the Month of: _____
In the amount of: \$ _____

Provider Name	Telephone #	Email Information
Mailing Address	City & State	Zip Code
1. Child's Number:	Child's Age:	
<p>Hourly (1-62) <input type="checkbox"/> Rate \$ _____ Per _____ # Hours _____</p> <p>Part-Time (63-135 hours) <input type="checkbox"/> Rate \$ _____ Per _____ # Days _____</p> <p>Monthly (136-215 hours) <input type="checkbox"/> Rate \$ _____ Per _____</p> <p style="text-align: right;">Total Charge For This Child \$ _____</p>		
2. Child's Number:	Child's Age:	
<p>Hourly (1-62) <input type="checkbox"/> Rate \$ _____ Per _____ # Hours _____</p> <p>Part-Time (63-135 hours) <input type="checkbox"/> Rate \$ _____ Per _____ # Days _____</p> <p>Monthly (136-215 hours) <input type="checkbox"/> Rate \$ _____ Per _____</p> <p style="text-align: right;">Total Charge For This Child \$ _____</p>		
3. Child's Number:	Child's Age:	
<p>Hourly (1-62) <input type="checkbox"/> Rate \$ _____ Per _____ # Hours _____</p> <p>Part-Time (63-135 hours) <input type="checkbox"/> Rate \$ _____ Per _____ # Days _____</p> <p>Monthly (136-215 hours) <input type="checkbox"/> Rate \$ _____ Per _____</p> <p style="text-align: right;">Total Charge For This Child \$ _____</p>		

Signature of Provider

Date