KTCCP Use Only

Invoice # _____

KTCCP Use Only

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:**

Hourly (1-157) ☐ **Rate $ _____ Per_____ # Hours _____**

Monthly (158-215 hours) ☐ **Rate $ _____ Per_____ # Days_____**

Total Charge For This Child $_____

2. Child's Number: **Child's Age:**

Hourly (1-157) ☐ **Rate $ _____ Per_____ # Hours _____**

Monthly (158-215 hours) ☐ **Rate $ _____ Per_____ # Days_____**

Total Charge For This Child $_____

3. Child's Number: **Child's Age:**

Hourly (1-157) ☐ **Rate $ _____ Per_____ # Hours _____**

Monthly (158-215 hours) ☐ **Rate $ _____ Per_____ # Days_____**

Total Charge For This Child $_____

_____ _____/_____/_____

Signature of Provider **Date**

Revised 09/04/2020