



COVID-19 Income Loss Support Program - Childcare Provider Time Sheet

Education, Employment and Supportive Services Division

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Child Care Provider's Name: _____ Parent/Guardian's Name: _____

Type of Care: 1) Relative _____ 2) Non-Relative _____ **Amount Charged Per Hour:** \$ _____

Child Care Period (Month): _____

Age	Child's Name	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total Hours

Comments: In the boxes above, in each day, enter the number of hours the child was in the providers care.

Parents: My signature below certifies that the child care hours documented was for single or both parents to attend employment, education, or training. I understand that Kawerak will check this information for accuracy with my employer, education or training facility.

Child Care Provider: My signature below certifies that I have provided child care for the parent/guardian. I understand if I have not provided child care the parent/guardian may be denied child care assistance.

Parent's Signature _____	Date _____	For Office Use Only This form was signed telephonically on _____ and verified by Kawerak, Inc. staff member _____
Provider's Signature _____	Date _____	

Total Cost \$ _____ (paid to provider)	For Office Use Only
Total Hours _____	EESS Staff Approval Signature: _____