KAWERAK, INC.

Child Care Services Program P.O. Box 948 Nome, AK 99762 www.kawerak.org Email: intake@kawerak.org
1-800-450-4341 or (907)443-4243 Fax (907)802-6183

Payment Certificate Time Sheet

Type of Care: 1) Relative: ☐ 2) Non-Relative: ☐ Child Care Month: _____
Licensed Providers must bill monthly by the 15th of each month. Tribally Approved Relative Providers may bill bi-weekly on the 15th or 30th.

Enter the number of hours for the day of the month each child was in the Provider's care.

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	Office Use

Parents: My signature below certifies that the childcare 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 childcare for the parent/guardian. I understand if I have not provided childcare the parent/guardian may be denied childcare assistance.

Parent (Print) **(Signature)** **Date**

Parent (Print) **(Signature)** **Date**

Provider (Print) **(Signature)** **Date**

Secondary Provider (Print) **(Signature)** **Date**

For Office Use Only: Total Cost $_____ **Parent Co-pay Amount $** _____ **(owed to provider)** **Subsidy Check Amount $** _____

Total Hours or Days FT / PT _____ **CC Coordinator Signature:** _____ **CC Specialist or Director:**_____