

Sold to: Department of Health & Human Services

Date: _____

**Maine Caring Families
Receipt for Child Care**

(Please Print)

Pay to: _____ SS #: _____

Address: _____

Child's Name _____ A# _____

Foster Parent's Name _____ Date Submitted _____

**Child Care Provider's Name: _____

Terms: Hourly Rate _____

Date(s) of Child Care _____

of Hours Total _____

Total Amount Due _____ (Hourly rate x # of hours).

I _____ paid the above named child care provider for child
(foster parent name)
care as described. I am requesting reimbursement for the rate and amount entered. Thank you.

**Child Care Provider's Signature: _____ Date: _____

Purpose:

Signature of Foster Parent: _____ Date: _____