STATE OF NEVADA
DIVISION OF WELFARE AND SUPPORTIVE SERVICES
Child Care and Development Program

Child Care Attendance and Provider Reimbursement Timesheet

Service Month: _____ Year: _____ Time Entered in NCCS ☐ Actual ☐ Schedule

Provider Information:

Name:	Tax ID:	Phone:
Mailing Address:		

Client/Child Information:

Child Name:	Child UPI:	Child DOB:
Client Name:	Client UPI:	Phone:

Client/Child Schedule this Month:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Week 1							
Week 2							
Week 3							
Week 4							
Week 5							

School Bell Schedule (if applicable):

Mon	Tues	Wed	Thurs	Fri

Schedule Notes: _____

Date	Day	Over night	Time In	Time Out	Time In	Time Out	Total Hours	Absent *	Initials	Date	Day	Over night	Time In	Time Out	Time In	Time Out	Total Hours	Absent *	Initials
1										17									
2										18									
3										19									
4										20									
5										21									
6										22									
7										23									
8										24									
9										25									
10										26									
11										27									
12										28									
13										29									
14										30									
15										31									
16																			

***Absent Reasons: Sick = S Vacation = V Track Break = T Discretionary Day = D Un-enrolled = U Loss of Contact = L Closed = C**

This Timesheet must be completed by the client daily with in and out times for all days the child was in attendance. If a discretionary day is used, a "D" must be placed in Absent Reason box and the client must initial that day. Any other absences to the Client/Child Schedule above must be indicated by an Absent Reason code (these do not need initials). All Timesheets must be submitted to the appropriate child care office no later than thirty days following the month of service. Timesheets submitted after thirty days are subject to non-payment.

We, the undersigned, certify the accuracy of the information submitted on this Timesheet and understand that this information may be audited by the State of Nevada, Division of Welfare and Supportive Services or its designee's and that any incorrect benefits paid will be recovered.

_____ _____
Client Signature Date Provider Signature Date

Is the client's co-payment current? ☐ **Yes** ☐ **No- Balance $** _____ ☐ **Bill Annual Fee- Amount: $**_____ ☐ **Bill Registration Fee- Amount $**_____

Please submit Timesheets for reimbursement to:

Northern Nevada
The Children's Cabinet, Inc.
Supporting Early Education and Development
1090 S Rock Blvd. | Reno, NV 89502
775-856-6210 | 775-856-6208 (fax)

Southern Nevada
Las Vegas Urban League
Early Childhood Connection
2470 N Decatur Blvd. #150 | Las Vegas, NV 89108
702-473-9400 |702-629-6232 (fax)

DISTRIBUTION: Original – Child Care Office, Copy – Provider