

LTBB CHILD CARE ASSISTANCE PROGRAM WEEKLY TIMESHEET



Parent/Guardian Name: _____
(Please print)

Please use blue or black ink to complete this form		CHILD 1		CHILD 2		CHILD 3		CHILD 4	
		Time In AM	Time Out PM	Time In AM	Time Out PM	Time In	Time Out	Time In	Time Out
DAY / DATE									
Sunday									
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									

Please ROUND to the nearest 1/4 hour. For example: 7:10 would be rounded up to 7:15; 7:05 would be rounded down to 7:00. The maximum payable hours are 40 per week. Please indicate in the comments section if there was a school closing, vacation or if the child was ill and unable to attend school.

Comments: _____

- I certify that the above information is correct and request payment for the hours of child care used.
- I understand that I can only count those hours that parent(s) are working, attending school or in an on the job-training program.
- I understand that I can only count those hours that my children are in child care with my approved provider.
- I understand that I am responsible for the portion of child care that is not paid for by the LTBB Child Care Assistance Program.
- I understand that the Tribe reserves the right to prosecute for any form of fraud or misrepresentation in receipt of benefits.
- I understand that timesheets turned into the LTBB Dept of Human Services that are found to be incomplete will not be paid until all information is obtained.
- I understand that I have the option of turning timesheets in on a weekly basis provided my child care provider is in agreement.
- **I understand if I choose to submit timesheets on a monthly basis, they will be date stamped by the LTBB Department of Human Services and will only be retroactive for payment 30 days from date stamped.**

This form must be signed by both the parent and the provider and the date entered cannot be before the last day services are rendered

Parent/Guardian Signature: _____

Date _____

Provider Signature: _____

Date _____

Provider Print Name: _____