

Department of Public Health & Social Services  
 DPW, Work Programs Section  
 123 Chalan Kareta Street, Mangilao, GU 96913-6304  
 671-735-7245

Service Month: \_\_\_\_\_  
 Year: \_\_\_\_\_  
 Case No: \_\_\_\_\_

**Child Care Calendar/Attendance and Provider Reimbursement Timesheet**

Provider Name: \_\_\_\_\_ Provider Tax ID: \_\_\_\_\_

Provider Address: \_\_\_\_\_  
 Street City Zip Phone

Child Name: \_\_\_\_\_ Child SSN/DOB: \_\_\_\_\_

Subsidy Parent Name: \_\_\_\_\_

DATE	DAY	TIME IN	TIME OUT	TIME IN	TIME OUT	TOTAL # of Hours	Client Signature for daily attendance	Comments
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								

*For Office Use Only* TOTALS: \_\_\_\_\_

The timesheet must be completed DAILY with the signature of the client or other authorized individual. If a client chooses to utilize a discretionary day the client must initial in the space provided for that date. A separate timesheet must be completed for EACH child. Timesheets must be COMPLETED and SIGNED by both the CLIENT AND PROVIDER at the end of each month to receive payment. Timesheets are DUE in the office listed above by 5:00 PM on the FIFTH business day of the month following the service period. Late or incomplete timesheets will be processed the following month.

Is the client's co-payment current? Yes \_\_\_\_\_ No \_\_\_\_\_ If NO, balance amount: \$ \_\_\_\_\_

Provider's Initials: \_\_\_\_\_

We, the undersigned, certify the accuracy of the information submitted and understand that this information may be audited by BES and that any overpaid benefits will be recovered.

\_\_\_\_\_  
 Parent Signature  
 \_\_\_\_\_  
 Date

\_\_\_\_\_  
 Provider Signature  
 \_\_\_\_\_  
 Date