DSS-EA-269 09/20 Case # ________________ Section 1

South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF ECONOMIC ASSISTANCE

PHONE:
FAX:
WEB: dss.sd.gov

Child Care Expense Billing Verification

Please complete the information below for:

____
(Name)

Please **DO NOT** include amounts billed to or paid by the SOUTH DAKOTA CHILD CARE ASSISTANCE PROGRAM, TRIBAL CHILD CARE ASSISTANCE, or any other source in the amounts below.

List the name(s), amount billed, how often billed and hours billed for each child that received care:

Child's Name	Amount billed	How often billed	Hours billed
	$__________	☐ Weekly ☐ Bi-weekly ☐ Twice a month ☐ Monthly ☐ Other __________	
	$__________	☐ Weekly ☐ Bi-weekly ☐ Twice a month ☐ Monthly ☐ Other __________	
	$__________	☐ Weekly ☐ Bi-weekly ☐ Twice a month ☐ Monthly ☐ Other __________	
	$__________	☐ Weekly ☐ Bi-weekly ☐ Twice a month ☐ Monthly ☐ Other __________	
	$__________	☐ Weekly ☐ Bi-weekly ☐ Twice a month ☐ Monthly ☐ Other __________	
	$__________	☐ Weekly ☐ Bi-weekly ☐ Twice a month ☐ Monthly ☐ Other __________	

*If more space is needed continue on the backside of this form

Provider Information:

Name: ____

Title: ____

Address: ______________________________ Phone Number: ______________

Provider Signature: ______________________________________