

ORDER FOR SUPPLIES/SERVICES (VOUCHER) VENDOR-RETURN TO DISTRI

Attachment 2.6.1

COUNTY DEPARTMENT OF SOCIAL SERVICES

NO. V1718946

NON SERVICES FOSTER CARE CHILD CARE VOUCHER SERVICES

SIGNATURE OF RECIPIENT, IF REQUIRED AUTHORIZED BY DATE

DATE OF ISSUE SERVICE/PAYMENT TYPE VENDOR ID VENDOR NAME AND ADDRESS

COUNTY DEPARTMENT OF SOCIAL SERVICES I HEREBY CERTIFY that the goods, materials, or articles enumerated in this bill have been actually performed and the services specified herein have been actually performed for and have been or will be to the use of the County Department or its recipient(s).

PERMIT/REGISTRATION ID #

IF YOU ARE NOT A LICENSED/REGISTERED PROVIDER, COMPLETE AND RETURN AN ENROLLMENT FORM.

SIGNATURE TITLE DATE ACCEPTED BY OFFICIAL CHECK NUMBER CHECK DATE

Table with columns: CASE NUMBER, AUTHORIZATION NUMBER, DESCRIPTION OF SUPPLIES OR SERVICES and/or RECIPIENT NAME, ADDRESS, ACCOUNT NUMBER, CIN AND SERVICE PERIOD/DATE OF DELIVERY, AMOUNT (AUTHORIZED, CLAIMED). Includes categories like DAY CARE CENTER, FAMILY DAY CARE, etc.

PAYMENT CANNOT BE AUTHORIZED UNLESS YOU PROVIDE A LEGAL FORM OF CHILD CARE. IF YOU PROVIDE SERVICES AS AUTHORIZED ABOVE, THE DEPARTMENT WILL PAY THE RATE YOU CHARGE OTHER PARENTS UP TO THE MARKET RATE, LESS ANY PARENT FEE, IF INDICATED

SERVICES HAVE OR WILL BE PROVIDED AS FOLLOWS:

DAYS OF CARE PROVIDED HOURS OF CARE/DAY HOURS OF CARE/WEEK \$ AMOUNT/WEEK BILLED

PROVIDER MUST SIGN AND RETURN THIS CERTIFICATE TO SOCIAL SERVICES BY IF DAY CARE SERVICES HAVE BEEN PROVIDED, VENDOR MUST ENTER AMOUNT.

TOTAL AMOUNT CLAIMED CANNOT EXCEED AMOUNT AUTHORIZED

NUMBER OF PAYMENTS DATE DUE

Pursuant to the provisions of Section 369 of the County Law of the State of New York, I do hereby certify that the labor or services, merchandise, materials or articles charged in the within account or claim, amounting to \$ have been actually performed, made or delivered for the COUNTY OF or for the County on behalf of a recipient(s); that the items and specifications therein are correct; that the prices charged therefor are reasonable and just; that no perquisites, commissions or allowances of any kind, other than as stated in the said account, have been or will be paid directly or indirectly, in consideration of the procurement of said articles or services; and that the said item or items contained in this bill or claim have not been, either in whole or any part, paid or satisfied and that the full amount is now justly due and that no part thereof has heretofore been presented for audit or payment.

CLAIMANT SIGNATURE DATE

Vendor, see other side for instructions for completion of this form

INSTRUCTIONS FOR VENDOR COMPLETION/USE

Copy 1 of this form (the white copy) must be returned to Social Services, Accounting, in order to receive payment from the Agency.

Provide only the services/supplies indicated in the Service/Payment Type area. Only provide these to the recipients indicated on the form.

Do not accept this form if you are not the vendor noted on the form, or if the form has been changed or defaced.

Please indicate the amount claimed for each case on the voucher, (and the attached list if one has been sent to you), and the total amount claimed on the bottom of the form. Do not include sales tax.

Note that if an authorized amount appears on the Voucher the agency will not pay a greater amount.

The Services that you have provide must have occurred during the services billing period printed on the form.

Social Services must also be in receipt of a bill for these services before payment will be made.

The yellow copy is for your files

CHILD CARE SUBSIDY CERTIFICATE

DATE OF ISSUE	CASE NUMBER:	UNIT OR WORKER NAME:	UNIT OR WORKER TELEPHONE NO.
PARENT/CARETAKER NAME:		NAME OF AGENCY/CENTER OR DISTRICT OFFICE:	
PARENT/CARETAKER ADDRESS:		ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE:	
DATE OF ISSUE:	CASE NUMBER:	UNIT OR WORKER NAME	UNIT OR WORKER TELEPHONE NO.
PARENT/CARETAKER NAME:		NAME OF AGENCY/CENTER OR DISTRICT OFFICE	
PARENT/CARETAKER ADDRESS:		ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE:	

The parent/caretaker has been authorized to receive child care assistance for the child listed below.
 The child care benefits are effective from 1/1/2011 to 5/1/2011.
 (A certificate must be issued for each child)

CHILD'S NAME	DATE OF BIRTH	CATEGORY OF CARE	MARKET RATES Maximum weekly rate	AGE RANGE
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		

PROVIDER INFORMATION

Social Services Districts can only pay licensed, registered or enrolled legally exempt child care providers.
 Social Services Districts must pay the applicable market rate unless the actual cost of care is less, in which case, the Social Services Districts must pay the actual cost of care. The Social Services Districts CANNOT PAY more than the maximum New York State market rates. If the cost of care is greater than the market rate the parent is responsible for the balance.

A certificate must be completed for each child receiving child care subsidy.
 The provider must complete the section below, sign and return this certificate to
 Albany County DCYF
 112 State Street
 Albany, NY 12207 by 3/20/11.

PROVIDER NAME AND ADDRESS	CCFS#	DAYCARE SERVICES <input type="checkbox"/> HAVE OR <input type="checkbox"/> WILL BE PROVIDED AS FOLLOWS:
		Days of Care Provided: _____ Hours of Care Per Day _____ Hours of Care Per Week _____ Dollar Amount Billed Per Week _____
Provider Signature:		Date:

This certificate is only valid for 30 days from the issued date and will expire on 3/20/2011.