

STATE OF NEW HAMPSHIRE  
 Department of Health and Human Services  
 Division for Children, Youth and Families  
 Child Care Services Invoice

**PROVIDER INSTRUCTIONS: FILL IN COMPLETELY AND MAIL ORIGINAL TO: DHHS, Data Management, PO Box 2000, Concord, 03302-2000, NH. PLEASE MAKE A COPY FOR YOUR RECORDS.**

Child Care Agency Name and Address:

Child's Name and Number:

Authorization Number:

Provider Number:

Authorization Period:

**Start Time, Stop Time and (A)bsent/(P)resent fields are required for each date of service child was in attendance or was scheduled to be in your care. The (A)bsent field is not to be used for days the child was not scheduled to attend.**

		Start Time	AM/PM	Stop Time	AM/PM	(A)bsent/(P)resent
Monday	1	_____	_____	_____	_____	_____
	2	_____	_____	_____	_____	_____
	3	_____	_____	_____	_____	_____
Tuesday	1	_____	_____	_____	_____	_____
	2	_____	_____	_____	_____	_____
	3	_____	_____	_____	_____	_____
Wednesday	1	_____	_____	_____	_____	_____
	2	_____	_____	_____	_____	_____
	3	_____	_____	_____	_____	_____
Thursday	1	_____	_____	_____	_____	_____
	2	_____	_____	_____	_____	_____
	3	_____	_____	_____	_____	_____
Friday	1	_____	_____	_____	_____	_____
	2	_____	_____	_____	_____	_____
	3	_____	_____	_____	_____	_____
Saturday	1	_____	_____	_____	_____	_____
	2	_____	_____	_____	_____	_____
	3	_____	_____	_____	_____	_____
Sunday	1	_____	_____	_____	_____	_____
	2	_____	_____	_____	_____	_____
	3	_____	_____	_____	_____	_____

Actual Amount Charged: \_\_\_\_\_

\_\_\_\_\_  
 Provider's Signature