MONTHLY INVOICE
CHILD CARE SUBSIDY PROGRAM
U.S. Department of Labor (DOL)

Month: _____ Year: _____

Childcare Provider Name: _____

DOL Employee (Parent) Name: _____

DOL Office/Agency (EBSA, ESA, OASAM, etc.): _____

Child1 Name: _____ Child1 Age: _____

Child2 Name: _____ Child2 Age: _____

Child3 Name: _____ Child3 Age: _____

Please indicate the total child care charges for services rendered each week during the month. The week ending date should always be on a Friday:

Week 1 Ending Date _____ Total Charges for Services Rendered: _____

Week 2 Ending Date _____ Total Charges for Services Rendered: _____

Week 3 Ending Date _____ Total Charges for Services Rendered: _____

Week 4 Ending Date _____ Total Charges for Services Rendered: _____

Week 5 Ending Date _____ Total Charges for Services Rendered: _____

Total Charges for the Month (most months will have 4 weeks): _____ $0.00

Please mail the monthly invoice to:

First Financial Associates
DOL CCSP
7079 Hayden Quarry RD
Lithonia, GA 30038

I certify that I am a full-time or part-time permanent employee of the U.S. Department of Labor (DOL); that my total family adjusted gross income (including my spouse's income) did not exceed $59,999; that my child/children listed above receive care in a licensed or regulated childcare facility; and my child/children is/are 13 years old or younger (18 years old or younger if my child/children is/are disabled). I understand that any assistance I receive from this program may be taxable income. I will notify First Financial Associates (FFA) in writing if and when my child/children are no longer enrolled in the childcare facility listed on my application. I understand that it is a crime to make a false statement on this form. If I make a false statement, I may be subject to criminal prosecution and punishment including a fine, imprisonment, or both. In addition, I may be subject to administrative punishment, including the termination of my federal employment.

I certify that the above information is true and correct to the best of my knowledge.

Parent Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Provider Title: _____