

# MONTHLY INVOICE

## CHILD CARE SUBSIDY PROGRAM

U.S. Department of Health and Human Services (HHS)  
Office of Secretary and Administration on Aging (OS/AoA)

Month: \_\_\_\_\_ Year: \_\_\_\_\_

Childcare Provider Name: \_\_\_\_\_

OS/AoA Employee (Parent) Name: \_\_\_\_\_

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): \_\_\_\_\_

I certify that I am a full-time or part-time employee of the U.S. Department of Health and Human Services (HHS) Office of Secretary and Administration on Aging (OS/AoA); that my total family adjusted gross income did not exceed \$50,000; 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 in writing if and when my child/children are no longer enrolled in the childcare facility listed on my application. I have provided a copy of my most recently filed Federal tax return, a copy of my most recent SF-50, Notification of Personnel Action (to verify my full-time or part-time status), and a copy of my most recent earnings statement. I understand that it is a Federal crime under United States Code 18, Section 1001, to make a false statement on this form. If I make a false statement, I agree to 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: \_\_\_\_\_