

**MONTHLY INVOICE**  
**CHILD CARE SUBSIDY PROGRAM**  
**Department of Veterans Affairs (VA)**

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

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

VA Employee (Parent) Name: \_\_\_\_\_

VA Organization Code (00, 10, 10M, 20, 40, 004, 00C, etc.): \_\_\_\_\_

Child1 Name: \_\_\_\_\_ Child1 Age: \_\_\_\_\_

Child2 Name: \_\_\_\_\_ Child2 Age: \_\_\_\_\_

Child3 Name: \_\_\_\_\_ Child3 Age: \_\_\_\_\_

Child4 Name: \_\_\_\_\_ Child4 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): \_\_\_\_\_

Please mail the monthly invoice to: **First Financial Associates**  
**VA CCSP**  
**7079 Hayden Quarry RD**  
**Lithonia, GA 30038**

I certify that I am a full-time or part-time employee of the Department of Veterans Affairs (VA); that my total family adjusted gross income (including my spouse's income) is less than \$60,000; 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 (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: \_\_\_\_\_