



**Form 101**  
 Billing Report Due by 3<sup>rd</sup> of each month  
**FILL OUT BILLING REPORT COMPLETELY**

Registered Family       Group       Center  
 Incomplete      Provider Expire: \_\_\_\_\_  
 Provider Completed Tribal Child Care Monitor Signature: \_\_\_\_\_

**OFFICE USE ONLY: income**

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

Name of Parent (Client)										Mailing Address										Phone Number						<input type="checkbox"/> Working <input type="checkbox"/> GED		<input type="checkbox"/> College <input type="checkbox"/> Highschool		<input type="checkbox"/> Training <input type="checkbox"/> Volunteer											
Name of Provider										Mailing Address										Phone Number						Billing Method <input type="checkbox"/> Hourly		<input type="checkbox"/> Weekly		<input type="checkbox"/> Daily											
1. Child's Name										Age		Hourly		Weekly		Daily		Rate		Total Amount						Total Hours															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31										
Actual hours of care																																									
2. Child's Name										Age		Hourly		Weekly		Daily		Rate		Total Amount						Total Hours															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31										
Actual hours of care																																									
3. Child's Name										Age		Hourly		Weekly		Daily		Rate		Total Amount						Total Hours															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31										
Actual hours of care																																									
4. Child's Name										Age		Hourly		Weekly		Daily		Rate		Total Amount						Total Hours															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31										
Actual hours of care																																									
5. Child's Name										Age		Hourly		Weekly		Daily		Rate		Total Amount						Total Hours															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31										
Actual hours of care																																									

I hear by certify that the information on this is true and complete to the best of my information and knowledge. I agree to promptly report to the TM Child Care Program any change or correction in the information shown on this form. I further agree that if this form or parent listed is selected for field review, my signature below constitutes my consent to obtain verifying information from any necessary source.

Provider's Signature	Parent's Signature	Date
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