SAMPLE FORM

REMITTANCE ADVICE

1344 Silas Deane Hwy
Rocky Hill, CT 06167-1342
1-888-214-KIDS (5437)

For services provided during:
Invoice number: Check
Number: Check Amount: $
Check Date:

Provider ID:
Provider SSN/FEIN:
Phone number:

NAME of CENTER
Mailing Address

City, State Zip

Child				Payment Calculation							
Child Name	Certificate Number	Family ID Number	Child with Special Needs?	Care 4 Kids Basic Rate per Month	Payments from Other Sources	Additional Hours Supplement	Supplemental Special Needs Payment (+)	Family Fee	Adjustment +)	Net State Payment for Child	Incentive Payment to Provider
										$	
										$	

Sub Totals: $ *A.*

A. Total payments for children in care: $
Quality Bonus and Reimbursement for Underpayments (+) $
Deductions (e.g., liens, recoupment due to provider error, etc.) (-) $
B. Total other provider payment adjustment (if applicable): $
C. NET PAYMENT: $

[1]If applicable, payments from other sources are outside funds paid to the provider for the care of the child (e.g. child support payments).
[2] If applicable, these are supplemental special needs payments to provide services for the child. These may be ongoing or for this month only.
[3] If applicable, this includes child-related adjustments due to overpayments/underpayments. These adjustments apply to the child for a previous month of care.
If applicable, includes incentive payments per child for providers that are accredited with NAEYC, NSACCA, NAFCC, CASFC.

SPACE for PRINTING of CHECK