Care 4 Kids
1344 Silas Deane Highway
Rocky Hill, CT 06067-1339
Phone: 1-888-214-5437
Fax: 1-877-868-0871

[Provider Name]
[Address Line 1]
[Address Line 2]
[City, State, Zip Code]

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Provider Id: **[Vendor ID]**
Phone Number: **[Phone #]**
Issue Number: **[Issue #]**
Issue Amount: **[Issue Amt]**
Issue Date: **[Issue Date]**

Child			Payment Calculation										
Child Name	Certificate Number **----------** Case Number	Child with Special Needs?	Invoice Number	Service Month	Care 4 Kids Basic Rate per Month 1	Registration Fee (+)	Additional Hours Supplement (+)	Non-Traditional Hours Supplemental (+)2	Monthly Family Fee (-)	Underpayment Adjustment (+)3	Overpayment Adjustment (-)3	Incentive Payment to Provider (+)4	Net State Payment for Child
[Child first name last name]	[Cert #] [Case #]	[Y/N]	[Invoice #]	[Service Month]	[Amt.]	[Amt.]	[Amt.]	[Amt.]	[Amt.]	[Amt.]	[Amt.]	[Amt.]	[Amt.]
[Child first name last name]	[Cert #] [Case #]	[Y/N]	[Invoice #]	[Service Month]	[Amt.]	[Amt.]	[Amt.]	[Amt.]	[Amt.]	[Amt.]	[Amt.]	[Amt.]	[Amt.]

Sub Totals: $[Amt.]

Provider Manual Payment/One-Time Incentive	
Provider Payment Type	Net State Payment
[Manual Payment Type]	[Manual Payment Issuance Amt]

A. Total payments for children in care: $[Amt.]
Total Family Fee: $[Amt.]
Total Quality Bonus, Accreditation, and Non-Traditional Payments: $[Amt.]
Reimbursement for Underpayment: $[Amt.]
Deductions due to Overpayment: $[Amt.]
B. Provider Manual Payment/One-time Incentives (e.g. POP reimbursement): $[Amt.]
C. Deductions (e.g., liens, Union dues etc.): $[Amt.]
D. Total C4K Payment Amount: $[Amt.]

1 If applicable, supplemental special needs payments are included in the base rate if the child is with special needs. These may be ongoing or for this month only.
2 If applicable, these are supplemental payments to provide non-traditional hour services for the child.
3 If applicable, this includes child-related adjustments due to overpayments/underpayments. These adjustments apply to the child for a previous month of care.
4 If applicable, includes incentive payments per child for providers meeting quality and accessibility indicators.
[Retroactive Manual Payment Text]
[Longevity Manual Payment Text]

Electronic Payment Summary

[Provider Name]
[Address Line 1]
[Address Line 2]
[City, State, Zip Code]

Issue Number: [Issue #]
Issue Amount: [Issue Amt]
Issue Date: [Issue Date]