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]**

Provider Id:
Phone Number:
Issue Number:
Issue Amount:
Issue Date:

Registration fee reimbursement charged to families (excludes unlicensed providers)

If applicable, payment amount for pre-approved additional hours

Parent monthly family fee

Providers only with an approved accreditation incentive

Total monthly payment amount per child

| 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] |

Manual Payments/One-Time Incentives are listed separately from regular monthly payments

**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.]

Total family fee amount deducted for all families

Total amount paid to the provider

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 Amount:
Issue Date: