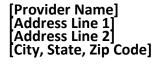


Care 4 Kids 1344 Silas Deane Highway Rocky Hill, CT 06067-1339 Phone: 1-888-214-5437

Fax: 1-877-868-0871



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

Total monthly Providers only payment with an approved amount accreditation per child incentive

Child		Payment Calculation										\perp	
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.]

Manual Payment Type]	[Manual Payment Issuance Amt]					
	, , , , , , , , , , , , , , , , , , , ,					
Manual Payments/One- Time Incentives are listed	A. Total payments for children in care: Total Family Fee: Total Quality Bonus, Accreditation, and Non-Traditional Payments: Reimbursement for Underpayment: Deductions due to Overpayment:					
separately from B. Provider Manual F regular monthly payments	Payment/One-time Incentives (e.g. POP reimbursement): C. Deductions (e.g., liens, Union dues etc.):	\$[Amt.] \$[Amt.] \$[Amt.] \$[Amt.]				

- If applicable, this includes child-related adjustments due to overpayments. 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: