CHILD CARE ASSISTANCE PROGRAM
ATTENDANCE AND BILLING REPORT

KODIAK AREA NATIVE ASSOCIATION

Parent First & Last name

Billing for Month Year

Provider Name Phone Number Provider Type

Mailing Address City, State, Zip Code

Program Contact: **Call: (907) 486-9879 Fax: (907) 486-1340**
Email: KANAchildcare@kodiakhealthcare.org

*Billed amount should reflect the total being billed for the month. Charges in excess of KANA reimbursement rates are the parents' responsibility in addition to their co-pay.

Please allow our office 10 business to process payment and hold calls about payment status until 10 business days have passed.

Use codes: F = Full time, P = Part time, O = Over time, A = Absent, H = Holiday, S = Sick
Part time = up to 5 hours, Full time = 5 hours, 1 min through 10 hours, Overtime = 10 hours 1 minute or more.
Age Groups; I = Infant, T = Toddler, P = Preschool, S = School Age

Child's First & Last Name	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	Total Days Attended P/T	Total Days Attended F/T	Age	Provider Billed Amount	KANA Maximum Approved Amount	Co-pay + Amount Over Max Approved	Subsidy Amount
C																																		I T P S				
Office Use Only:	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	P/T	F/T					
C																																		I T P S				
Office Use Only:	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	P/T	F/T					
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C																																		I T P S				
Office Use Only:																																						
																																		Subtotal:				

Notes:

Provider Signature below is required for payment.
Processing of Billing Reports without signature may be delayed.
Certification Statement: I certify that the information provided on this form is true and correct and the parents have agreed upon arrangements.

Provider Signature Date

Case Manager Signature Date