

CLAIM COVER SHEET

(AR 608-10)

Date _____
month day year

Provider's Name _____

Claim from _____ to _____

Total # of daily meal records _____ Total # of infant menu's _____

Weekend care? Yes _____ No _____

Extended care? Yes _____ No _____ Over three days _____ ?

Subsidy? Yes _____ No _____

I provided back up care for the following providers: _____,
_____. No back up care provided _____.

New Enrollments

<u>Child's Name</u> (Last, First, MI)	<u>Enrollment Date</u> (MO/DA/YR)	<u>Handicapped?</u> Yes/No	<u>Foster child?</u> Yes/No	<u>Special Diet?</u> Yes/No
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Child(ren) Dropped From Program

<u>Child's Name (Last, First, MI)</u>	<u>Date: (Last Day of Care)</u>
_____	_____
_____	_____
_____	_____
_____	_____

Contract change

Change: Meal time _____ Add/Delete weekend care from Contract _____ Address _____
Dropping from Program Last Claim _____

Provider Signature _____ Date _____

Staff Signature _____ Date _____