



## DAYCARE DEDUCTION VERIFICATION FORM

Client Information	
Client No.	
Name	
Address	
Phone No.	

Facility Information	
Name	
Address	
Phone No.	

Payment Information ( Please specify)	
Total Amount Paid	\$ Per week, biweekly, monthly
Amount Paid by Special Programs	\$ Per week, biweekly, monthly
Amount Actually Paid by Client	\$ Per week, biweekly, monthly

Signature of Provider \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

Title \_\_\_\_\_

Phone No. \_\_\_\_\_

