Continuity of Care Claim
Authorization to Pay Form

Early Learning
psesd
excellence & equity in education
Puget Sound Educational Service District

Invoice # CC -

Center Directors and FCC Providers
Request payment of COC funds within 90 days of service. The limits of this funding will be detailed on the approved request form. Attach copy of approved request form with claim for reimbursement. Highlight the name of the child for which you are receiving COC funds.

Center Name _____

Address _____
(where payment is to be mailed)

_____

Child's Name and DOB: _____

Dates approved by PSESD: _____

Max. days approved by PSESD (# of days): _____

Rate (per day): _____

Max. reimbursement amount approved by PSESD: _____

To be completed by Center:

Number of Days Requested: _____(Attendance sheet must be attached with child's name and attendance highlighted)
Total amount requested $ _____ (# of Days Requested x Rate)

_____ _____
Center Staff/Provider Signature **Date**

☐ **I will be billing for additional days on this claim (CC -). Please keep it open for future payments.**
Without this box checked, future payments submitted against this claim will be delayed.

If center receives retroactive child care payments at a later date, the center is obligated to return COC funds to PSESD.

For Fiscal use only:

Fiscal Initials & Date _____

Account Code: XXXX-XXXX (changes annually) $ _____

_____ _____
Manager's Signature Date

_____ _____
Executive Director's or Designee's Signature Date