

Care Invoice

Provider: _____

INVOICE # _____

DATE: _____

PARENT / GUARDIAN:

TODDLER NAME:

BILLING PERIOD:

___ / ___ / ___ to ___ / ___ / ___

Day	Hours / Shift	Rate	Amount
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			

Additional Fees (Meals/Late/Activity):

NOTES / OBSERVATIONS:

TOTAL DUE: \$ _____

Payment Due By: _____

Method of Payment: Cash Check Electronic Transfer

Thank you for trusting us with your child's care!