



CCEH Children in Shelters Child Care Assistance Fund Payment Request Form

Childcare Provider Name _____

Phone _____

Mailing Address:

Amount requested (invoice required): \$ _____

Service Type (check all that apply): _____ Childcare

For Childcare Assistance - Dates of Coverage for the attached invoice:

Start Date: _____ End Date: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Check Made Payable to:

Mailing address:

Signature: _____ Date: _____

Please attach an invoice for the dates covered by this request.
Payment requests must be faxed to CIS Program at 860-257-1148