Kids Crossing

Monthly Billing Form

Month:_____ **Year**:_____

Name of Child	Level	Date In	Date Out	Amount

PLEASE SUBMIT THIS FORM BY THE 4TH BUSINESS DAY FOLLOWING THE MONTH OF CARE.

PRINT FOSTER PARENT'S NAME(S): _____

Foster Parent's Signature: _____ Date:_____

Care Coordinator's Signature : _____ Date:_____

Questions or problems? Call Carla Londo at 667-7061.