Wichita and Affiliated Tribes
Child Care Services
Providing a Strong Foundation for our Children's Future

CONTRACT VOUCHER

The following children are eligible for assistance from the Wichita and Affiliated Tribes Child Care Program:

			Office Use Only Do Not Fill Out	
Name	Age	D.O.B	Wks, Days, Hrs	Amount Due
			__Weeks @ $____ __ Days @ $____ __ ½ Days @ $____ __Hours @ $____	
			__Weeks @ $____ __ Days @ $____ __ ½ Days @ $____ __Hours @ $____	
			__Weeks @ $____ __ Days @ $____ __ ½ Days @ $____ __Hours @ $____	
			__Weeks @ $____ __ Days @ $____ __ ½ Days @ $____ __Hours @ $____	
			__Weeks @ $____ __ Days @ $____ __ ½ Days @ $____ __Hours @ $____	

Parental Fees: No ___ Yes___ Amount $_____

Parent Information	Provider Information
Name:	Name:
Address:	
City/State/Zip:	
Phone:	
Signature:	

Enrollment Verification – Office Use Only

CCDF Director: ___Yes ___ No Signature: _____ Date: _____
Enrollment Officer ___Yes ___ No Signature: _____ Date: _____
Finance Officer: ___Yes ___ No Signature: _____ Date: _____