Attention Provider: Form Marked Original Must be Returned To:_____
By (Date):_____
Address: _____
Voucher No.:_____

EMERGENCY CHILD CARE VOUCHER
DIVISION OF CHILD DEVELOPMENT
DEPARTMENT OF HEALTH AND HUMAN SERVICES

(PLEASE PRINT)

Child's Name:_____ Child ID No.:_____

Child's Age and/or Date of Birth:_____

Parent's Name or Guardian's Name:_____

Address (indicate if a relative's or friend's address):_____

_____

Telephone Number (indicate if relative's or friend's telephone number): ( )_____
Eligibility Period of Care: From:_____ Through:_____ **(maximum of four months)**

Hours Care is Needed: From_____ a.m./p.m. Through_____ a.m./p.m.
From_____ a.m./p.m. Through_____ a.m./p.m.
Parent's or Guardian's Name (Please print.):_____
Signature of Parent/Guardian:_____ Date Signed:_____

Agency Section: County:_____ Date Form Completed:_____
FEMA Claim Number):_____ Family Case Number: **EMERGY**
CATEGORY CODE: 019 **FUND SOURCE:** 85
Need Code for Child Care and/or Transportation. Circle the code number(s) that apply.
 # 851: 100% Care **# 852:** 75% Care **# 853:** 50% Care **# 859:** Transportation
Agency Representative Signature:_____ Date:_____
Print Agency Representative Name:_____

To be completed by Child Care Provider:
Provider Name:_____ Telephone: ( )_____
Name of Facility:_____
License No. or Facility ID No., if assigned:_____
County in which care is given:_____
Location (address) of where child care is provided:_____

_____

Owner/Sponsor of Program:_____ Telephone: ( )_____
Mailing Address:_____
Person Completing Voucher (Please print and sign name):_____

_____

Provider's Social Security No. or Tax ID No.:_____ Date Child Enrolled:_____
COMMENTS: _____

_____