

**KY FOSTER & ADOPTIVE PARENT TRAINING SUPPORT  
NETWORK  
CHILDCARE EXPENSE REPORT**

Foster Parent \_\_\_\_\_ Date of Report \_\_\_\_\_

Social Security Number \_\_\_\_\_

Mailing Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Telephone ( ) \_\_\_\_\_

Region \_\_\_\_\_

Date(s) of Childcare Services:	Number of Children:
Total Time (hours or days):	Rate per child: \$ _____ hour or day <i>(circle one)</i>
Name of Childcare Provider:	Total Paid to Childcare Provider: \$ _____
Address of Childcare Provider:	
Telephone: ( ) _____	
Reason:	

Foster Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Childcare Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

To be eligible for reimbursement:

- all sections of this form must be completed (including signatures);
- the expenses must relate to Network activities;
- the original form must be submitted;
- all forms should be submitted within the fiscal year the expenses are incurred; and
- the rate should not exceed the current state respite rate for the level of child in care.