Early Childhood Connections
"Live the Possibilities"
2501 East 13th Street Hays, KS. 67601
785-623-2430
Fax 785-623-2432

Quality Enhancement

This statement must be completed monthly and sent to Early Childhood Connections by the tenth of the month.
Payment will be made by USD 489.

Provider's Name: _____ Address: _____

Social Security Number: _____Phone Number: _____Month Of: _____

CHILD CARE COST

(ATTACH ATTENDANCE SHEET)

First & last name of enrolled Early Head Start Children	Total hours of attendance		DCF OR KVC Amount Received
1.			
2.			
3.			
4.			
5.			
6.			
	Total hours:		Total DCF:
	KEHS hours:	FED hours:	Total KVC:

KEHS: 07 e 1000 323 7900 982 _____ hours x 4.35= $_____-DCF/KVC=_____=Total_____

Federal: 07 e 1000 323 7900 971 _____ hours x 4.35= $_____-DCF/KVC=_____=Total_____

Total $ _____

TRAINING

Verifications of training hours will be determined by attaching certificate of training and/ or bill for training.

Title of Training	Hours	Hour Amount	Total Amount
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

KEHS: 07 e 2213 580 7900 982 _____%

Federal: 07 e 2200 330 7900 971 _____%

Total $_____

OTHER APROVED EXPENSES

(Attach copy of receipts as needed for other expenses)

	Number of EHS Children	Fee per child	Total
Supply Allowance Monthly $5.00 for each EHS enrolled student (no receipt needed)		X $5.00	
Lesson Plans		X $10.00	
Observations		X $10.00	
Parent-Teachers Conference (2 X Year)		X $10.00	
Monthly Childcare Meeting		$10.00	
Other Expenses (receipts needed)	N/A		
	Total Expenses:		**$ _____**

KEHS 07 e 1000 323 7900 982 _____%
Federal 07 e 1000 323 7900 971 _____%

MILEAGE TO ATTEND REQUIRED TRAINING/MEETINGS

(FROM YOUR LOCATION TO HAYS)

Miles _____ x.56 = $_____ **Total Mileage $_____**

KEHS 07 e 2213 580 7900 982 _____%
Federal 07 e 2213 580 7900 971 _____%

Grand Total: $_____

_____ _____
Signature of Provider **Date**

_____ _____
Signature of Early Childhood Connections Director **Date**

_____ _____
Signature of Early Head Start Coordinator **Date**