

Documentation of Absences for School Readiness Child

This form must accompany attendance sheet for current month to be CONSIDERED for payment. This form is to be used when a child exceeds the allotted 3 days per calendar month. Seven (7) additional days are available for reimbursement with this form as indicated **6M-4.500 Reimbursement-General Provisions Regarding Reimbursements for Holidays and Absences**.

ONE CHILD PER FORM

Provider: _____ Month: _____ Year: _____

Contact Person: _____ Phone Number: _____

Childs Name	Date(s) of absences that exceed the first 3 allowed	Documentation attached (Yes or No) **

Important Note: Payment is **not** guaranteed and may be jeopardized if there is no documentation included. If denied, it is the parent's responsibility to reimburse provider for days not reimbursed by the ELCFH School Readiness Program.

X	Extraordinary circumstances include the following below:	ELCFH REQUIRES	
		Additional Documentation	Parent Signature on this form
<input checked="" type="checkbox"/>	1.) Hospitalization of child or parent with appropriate documentation (i.e. doctor note)	Y	N
<input type="checkbox"/>	2.) Death in the immediate family with appropriate documentation (i.e. obituary, death certificate)	Y	N
<input type="checkbox"/>	3.) Court order visitation with appropriate documentation (i.e. court order)	Y	N
<input type="checkbox"/>	4.) Unforeseen documented military deployment or exercise of the parents	Y	N
<input type="checkbox"/>	5.) Illness requiring home-stay, please state illness:(i.e. diarrhea, fever) _____	N	Y*
<input type="checkbox"/>	6.) Extraordinary circumstances beyond the control of the child or parent. _____	Y	Y*

I certify that the information given is true and complete. I understand that if I give false information my case may be referred to the Florida Department of Law Enforcement for action. I understand that payment is not guaranteed and if payment is denied it will be my responsibility to reimburse the provider for the days not reimbursed by the ELCFH School Readiness program. I understand that ELCFH will follow Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

* Parent Signature: _____ Date: _____

see # 5 & # 6 above

Provider Signature: _____ Date: _____

For ELCFH Office Use Only

Requested within required time lines: Yes No

Date Submitted: _____

Documentation Included: Yes No

Reason coincided with policy: Yes No

Approved: Yes No

Reason: _____

Signature of ELCFH Designee: _____ Date: _____



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