Early Learning Coalition of Florida's Heartland, Inc.

www.elcfh.org

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 Child Attendance and Provider Reimbursements.***

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	ELCFH REQUIRES Parent Signature on this form
☐	1.) Hospitalization of child or parent with appropriate documentation (i.e. doctor note)	Y	N
☐	2.) Death in the immediate family with appropriate documentation (i.e. obituary, death certificate)	Y	N
☐	3.) Court order visitation with appropriate documentation (i.e. court order)	Y	N
☐	4.) Unforeseen documented military deployment or exercise of the parents	Y	N
☐	5.) Illness requiring home-stay, please state illness:(i.e. diarrhea, fever) ______	N	Y *
☐	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 by my responsiblity 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: __________

United Way of Central Florida

United Way

Charlotte Office
2886 Tamiami Trail, Suite 1
Port Charlotte, FL 33952
Phone: (941) 255-1650
Fax: (941) 255-5856

Highlands Office
6432 US HWY 27 South
Sebring, FL 33876
Phone: (863) 314-9213
Fax: (863) 314-4480

Office of Early Learning
Learn Early. Learn for Life.

"INVESTING IN CHILDREN – INVESTING IN OUR FUTURE"

Revised: 05-13-14