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:

1.) Hospitalization of child or parent with appropriate documentation (i.e. doctor note)
2.) Death in the immediate family with appropriate documentation (i.e. obituary, death certificate)
3.) Court order visitation with appropriate documentation (i.e. court order)
4.) Unforeseen documented military deployment or exercise of the parents
5.) Illness requiring home-stay, please state illness:(i.e. diarrhea, fever)

Y ELCFH REQUIRES

| X | ELCFH REQUIRES |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Parent Signature: ___________________________ Date: ___________

Provider Signature: ___________________________ Date: ___________

For ELCFH Office Use Only

Requested within required time lines: ☐ Yes ☐ No

Documentation Included: ☐ Yes ☐ No

Reason coincided with policy: ☐ Yes ☐ No

Approved: ☐ Yes ☐ No

Reason:

Signature of ELCFH Designee: ___________________________ Date: ___________

*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 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

** Required Documentation attached (Yes or No)