

Return to: Attention: Danielle Fagen Athens County Children Services P.O. Box 1046 Athens, OH 45701	Foster Parent: _____ Month/Year: _____ Name of Foster Child(ren): _____ _____ Caseworker: _____
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PAYMENT FOR CARE

<u>RATES</u>			
AGE 0-3: \$25/night	4-12: \$24/night	13-18: \$26/night	Beeper: \$8/night

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Number of days _____ X Rate _____ = \$ _____

Number of days _____ X Rate _____ = \$ _____

Number of days _____ X Rate _____ = \$ _____

Number of days _____ X Rate _____ = \$ _____

Number of days _____ X Rate _____ = \$ _____

TOTAL AMOUNT REQUESTED = \$ _____

Comments: _____

 Foster Parent Signature

NOTE: This billing form must be completed and returned to the agency by the **first working day of the month** in order to receive reimbursement by the end of the current month.