Foster Parent Claim Voucher

I, the undersigned foster parent, acknowledge by my signature that I have provided the services for which I am requesting payment. I further certify that this claim is in full compliance with the stipulations set forth in the agreement under which the claim is made.

Child's Name:	

Program:

- [ ] STFC Level I Placement
- [ ] STFC Level II Placement
- [ ] Therapeutic I Placement
- [ ] APD & Therapeutic II Placement

Date(s) the child was in the home:

from: ____________________ to: ____________________
mm/dd/yy *mm/dd/yy*

Number of **NIGHTS** claimed: [ ]

NOTE THE PAY PERIOD IS FROM THE 1ST OF EACH MONTH TO THE LAST DATE Of THE MONTH (FOR EXAMPLE 1/1/21 TO 1/31/21) OR THE DATE THE CHILD WAS PLACED IN YOUR HOME OR DISCHARGED.

Foster Parent Name: ____________________

Foster Home Address: ____________________
Address *City* *State* *Zip Code*

____________________ Foster Parent Signature ____________________ Date

____________________ Foster Parent Signature ____________________ Date

THIS FORM MUST BE SUBMITTED BY THE 3rd BUSINESS DAY OF EACH MONTH
FAX NUMBER: 813-200-1045

For office use only:

Date Received: ____________________ Electronic Deposit Date: ____________________

Revised 02.03.21