WEST CENTRAL ARKANSAS WORKFORCE DEVELOPMENT AREA
Childcare Invoice

Childcare Provider:	Representative:
Address:	Phone Number:
City/State/Zip:	

Participant:	County:	Program:	☐	ADULT	☐	DLW	☐	OSY

Date	Weekly Amount
Week of:	
Week of	
REIMBURSEMENT THIS PERIOD:	

By my signature, I agree to the above authorized services for the dates specified. I further agree that I will bill only for services actually provided. I further understand that WIOA is not liable for any payment for days not authorized by this form.

Childcare Provider Rep Signature Date Title

By my signature, I agree to the dates listed above. I further agree that I may be liable for any unauthorized payments to the Provider as a result of my non-compliance with program requirements.

Participant Signature Date

I have authorized the above services for the dates specified. All required information was received prior to finalizing these arrangements.

WIOA Staff Date