<u>Below are two different versions of the *Just in Time Care* Invoice Form.</u>

The first version is designed for *Just in Time Care* client companies whose employees are allowed to choose whether their subsidy money is sent to their backup care provider, or whether the money is reimbursed to the employee.

The second version is for *Just in Time Care* client companies who only permit the subsidy funds to be sent to the backup care providers.

If you have any questions about the type of *Just in Time Care* service that your company offers, please refer to your Enrollment Packet or call *Just in Time Care* at 800-537-5557 or 302-479-5101.

Complete a *Just in Time Care* invoice after the care takes place and have your provider sign it. You must also sign it.

Mail, fax, or e-mail invoices to *Just in Time Care* at Children & Families First.

Children & Families First
809 N. Washington St.
Wilmington, DE 19801
Phone: 800-537-5557 or 302-479-5101
Fax: 855-462-0426
E-mail: jitc@jitc.org

JUST IN TIME CARE® INVOICE FOR SERVICES PROVIDED

Invoice must be signed by the employee and the provider **after care is completed.** Make 3 copies of completed invoice: mail/fax/e-mail 1 to the *Just in Time Care (JITC)* program, employee keeps 1 copy, and provider keeps 1 copy.

__Important: please print clearly. If information is not readable, it may result in delay of payment.__

All invoices must be submitted no later than two months past the conclusion of your plan year, or your invoices will not be paid *(Consult your Enrollment Packet or call* Just in Time Care *for more details.).*

Employee and Care Information

Employer	
Employee Name	
Employee ID #	
Employee Work Telephone #	
Type of Care *(check one)*	___ Well care ___ Sick care
Reason for Care *(check one)* ___Child sick ___Adult/Elder sick ___Adult/Elder transition ___Business travel ___Evening/weekend business event ___Overtime	School closing: ___Scheduled ___Weather-related Provider: ___Sick ___Vacation ___Quits/closes ___Emergency
Dates of Care	
Hours of Care	
Dependent Name, Birthdate, and Relation to Employee	
Dependent Name, Birthdate, and Relation to Employee	
Full Cost of Care	$
Less Employee Portion of Cost	$
Subsidy to Be Paid*	$

Employee: I hereby certify that the information listed on this invoice is correct, and that the use of this care is work-related and short-term. I also certify that this provider meets the following requirements: is 19 years of age or older; has provided a social security # or tax ID #; is not my spouse/ partner, my child's parent, my adult/elder's child, or my adult/elder's spouse; and is not my regular care provider, unless being used for additional backup hours beyond the normal care schedule.

I accept responsibility for payment of services rendered if they are not reimbursed by my *JITC* account.

Employee Signature_____

**Amount to be paid is based on employer subsidy level, amount of money remaining in employee subsidy account, and any other guidelines set by the employer.*

Provider Information

Provider Name *(as it should appear on check)*	
Type of Care *(check one)*	___ Center ___ Family child care business ___ In-home agency ___ Family *(relation to employee:_____)* ___ Friend ___ Other: _____
Provider Telephone #	
Social Sec. # or Tax ID #	

Provider: I certify that I provided care to the dependents listed for the hours shown. In signing this invoice, I certify that I meet the *Just in Time Care* requirements (see bottom of first column), and that the information given by me in applying for payment under the *JITC* program is correct.

Care Provider Signature_____

Note to employee: *If your provider prefers receiving the full cost of care at the time of care,* Just in Time Care *can reimburse you the employer subsidy portion. Below, indicate whether the check is to be sent to you or your provider.*

____Send payment to employee ____Send payment to provider

Make check payable to:

Street address:

City:

State: Zip:

___*check here if this is a new address*

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Employee and Care Information

Employer	
Employee Name	
Employee ID #	
Employee Work Telephone #	
Type of Care *(check one)*	___ Well care ___ Sick care
Reason for Care *(check one)* ___Child sick ___Adult/Elder sick ___Adult/Elder transition ___Business travel ___Evening/weekend business event ___Overtime	School closing: ___Scheduled ___Weather-related Provider: ___Sick ___On vacation ___Quits/closes ___Emergency
Dates of Care	
Hours of Care	
Dependent Name, Birthdate, and Relation to Employee	
Dependent Name, Birthdate, and Relation to Employee	
Full Cost of Care	$
Less Employee Portion of Cost	$
Subsidy to Be Paid*	$

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Employee Signature_____

**Amount to be paid is based on employer subsidy level, amount of money remaining in employee subsidy account, and any other guidelines set by the employer.*

Provider Information

Provider Name *(as it should appear on check)*	
Type of Care *(check one)*	___ Center ___ Family child care business ___ In-home agency ___ Family *(relation to employee:_____)* ___ Friend ___ Other: _____
Provider Address ___ *check here if this is a new address*	Street address: City: State: Zip:
Provider Telephone #	
Social Sec. # or Tax ID #	

Provider: I certify that I provided care to the dependents listed for the hours shown. In signing this invoice, I certify that I meet the *Just in Time Care* requirements (see bottom of first column), and that the information given by me in applying for payment under the *JITC* program is correct.

Care Provider Signature_____

By participating in the *Just in Time Care* program, the employee agrees that neither your employer nor Children & Families First will have any liability, direct or indirect, for the actions of any particular provider or any adverse consequences that may arise in connection with the use of the *Just in Time Care* program.

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