



REQUEST FOR REIMBURSEMENT EXTRAORDINARY CIRCUMSTANCE ABSENCE

(For 10 additional days per month)

Each child is allowed a maximum of 3 absences per calendar month. Additional absences during the month may be for extraordinary circumstances and approved by the Coalition. Submission of this form does not guarantee payment for extraordinary absences. Incomplete and/or unsigned forms will not be accepted for reimbursement.

Child's Name: _____ ID / SSN#: _____

Parent's Name: _____ Care Provider: _____

Required Parent Signature: I understand my provider is requesting payment for days of extraordinary absence(s) for my child. I am aware that I can lose my school readiness subsidy and/or be prosecuted for fraud if I provide false information.

Signature of Parent: _____ Date: _____

	Absence Date	Absence Code	Explanation of Absence
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			

ABSENCE CODE LEGEND:

- I** = Illness/injury requiring homestay
- H** = Hospitalization of child/parent with appropriate documentation
- C** = Court ordered visitation with copy of Court Order
- D** = Death in immediate family with copy of Death Certificate/obituary
- M** = Unexpected documented military deployment or exercise

Upload this completed and signed form to your monthly attendance sheet that has the absence noted. Questions? Contact the Coalition at 983-4710

Printed Name of Facility: _____

Authorized Signature: _____