



**REQUEST FOR REIMBURSEMENT
EXTRAORDINARY CIRCUMSTANCE ABSENCE**

(For 7 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 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: _____

	ABSENT DATE	ABSENT CODE	Explanation of Absence(s):
4			_____
5			_____
6			_____
7			_____
8			_____
9			_____
10			_____

- ABSENT 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: _____