Catastrophic Illness in Children Relief Fund
250 Washington Street, 5th floor
Boston, MA 02108-4619
1-800-882-1435

Receipt for Child Care Services for Siblings

CICRF does not pay for routinely scheduled child care, but will consider temporary child care while the applicant child is receiving medical care.

Child(ren) cared for: ____________________________ Date of Birth: ______________________

____________________________ Date of Birth: ______________________

____________________________ Date of Birth: ______________________

Parent's name: ____

Parent's address: ____

Child Care Provider's name: ____

Child Care Provider's address: ____

Child Care Provider's license number, if applicable:____

Child Care Provider's phone number:____

Payment rate: $_________________ Total Payment received: $__________________________

Exact dates of service (**required**): ____

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I hereby swear, under the pains and penalties of perjury, that the information I have provided is accurate and complete, and that these are child care costs that would not have been incurred except for my child's illness.

I give permission for CICRF staff to contact the above named Child Care Provider.

Parent/Guardian Signature: ________________________________ Date: __________________

I hereby swear, under the pains and penalties of perjury, that the information provided above is accurate and complete, and that I have received the amount paid indicated above.

Child Care Provider Signature: ____________________________ Date: ____________________