

**Department of Human Services
Division of Family Development
Office of Child Care Operations
ECC Attendance Log**

Return to:		Community Coordinated Child Care of Union County PO Box 609 Union, NJ 07083			County:		
Provider Name:				EPPIC #:			
Site/Location Address:				Phone:			
Child's Name:		Parent's Name:			Case #:		
Check One	<input type="checkbox"/> WFNJ	<input type="checkbox"/> NJCK (CCAP)	<input type="checkbox"/> CPS or PACC	<input type="checkbox"/> DOE Wrap			
Instruction – This attendance log is a backup form and specific to ECC. Please note – this form <u>does not</u> replace the parents' requirement to check their child(ren) in and out daily using the ECC system. Send to CCCC of UC along with the payment discrepancy form immediately when information was not properly recorded in ECC.							
	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Week of:							
Check-In Time:							
Check-Out Time:							
Week of:							
Check-In Time:							
Check-Out Time:							
I CERTIFY THIS IS AN ACCURATE ACCOUNT OF ATTENDANCE FOR THE CHILD REFERENCED ABOVE.							
Both the Parent and Provider must sign and date below							
Parent's/Guardian Signature				Date:			
Provider's Signature				Date:			

FOR OFFICE USE ONLY (Do not write below this line):

EPPIC Agreement #:

Total # of Days:

Daily Rate:

Weekly Copay:

# OF DAYS X DAILY RATE	TOTAL COPAY FOR VOUCHER PERIOD	PAYMENTS ALREADY RECEIVED	TOTAL ADJUSTMENT DUE
Comments:		Prepared by:	
		Date:	
		Adjusted by:	
		Date:	

**New Jersey Department of Human Services
Division of Family Development
Office of Child Care Operations**

E-Child Care Provider Payment Discrepancy Form

Name of CCR&R Agency: Community Coordinated Child Care of Union County Date: _____

EPPIC ID Number: _____ Telephone: _____

Name of Provider: _____

Provider's Address: _____

POS User

IVR User

New address and/or phone number: Y / N

Please complete and submit Proof of Attendance

Please complete and write reason or any additional information you think we will need.

*I was **not paid** accurately or **at all** for the child(ren) listed below on the POS indicated below:*

1. _____ FT PT From: _____ To: _____
Child's Name POS

Details: _____

2. _____ FT PT From: _____ To: _____
Child's Name POS

Details: _____

3. _____ FT PT From: _____ To: _____
Child's Name POS

Details: _____

4. _____ FT PT From: _____ To: _____
Child's Name POS

Details: _____

5. _____ FT PT From: _____ To: _____
Child's Name POS

Details: _____

6. _____ FT PT From: _____ To: _____
Child's Name POS

Details: _____

Provider Signature: _____ Date: _____

Child Care Resource and Referral Finding and Action Taken

Verified information in EPPIC Y / N Other: _____

Checked Agreement in Source System Y / N _____

Reviewed Attendance Log Y / N _____

Outcome of Finding and/or Action Required

Adjustment Made in AT _____ No Discrepancy Found _____

Manual Claim Required _____ Other: _____

Staff Signature: _____

Supervisor's Approval: _____

Please submit this form immediately to: Fax #: _____ or by mail to:

Please allow a minimum of 5 days for this issue to be researched and reviewed for adjustment on the next payment cycle.
