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

Return to: ⇨ **(Name/Address of CCR&R)**	Community Coordinated Child Care of Union County 2 City Hall Plaza, 3rd Floor Rahway, NJ 07065	**County:** **UNION**
Provider Name:		**EPPIC #:**
Site/Location Address:		**Phone:**
Child's Name:	**Parent's Name:**	**Case #:**

Check One	☐ **WFNJ**	☐ **NJCK (CCAP)**	☐ **CPS or PACC**	☐ **DOE Wrap**

Instruction – This attendance log is a backup form and specific to ECC. Please note – this form does not 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
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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.

_____
_____
_____