

[LE-21] Safety & Quality Enhancement Reimbursement Form

For License Exempt Family Child Care Providers Participating in ERDC Subsidy

Who is eligible? License exempt Family Child Care Providers participating in ERDC Subsidy.

What is reimbursable? The reimbursement will be available for the cost of equipment, or facility repairs that were directly paid by the program and have not been paid by a third party to help comply with DELC health and safety requirements. The reimbursement shall not exceed two hundred and fifty dollars (\$250.00) per year.

Requirements for reimbursement:

1. Original Receipt/s showing payment.
2. WOU Substitute W-9.

Do you provide child care to infants or toddlers (ages 0-3)? **Yes** **No**

| | |
|-------------------|--------------------|
| Provider Name | Date |
| DELIC Provider ID | () Phone # |

| Date of Purchase | Type of equipment, or repair | Cost per item | What need does this item/service meet? | For office use only: Approval (Y/N) |
|------------------|------------------------------|---------------|--|--|
| | | | | |
| | | | | |
| | | | | |

Attach additional pages if needed

How did you learn about this reimbursement?

Local CCR&R ERDC Listing Form Licensing Specialist Other: _____

Payment Information: (Must match WOU Substitute W-9.)

| | | | |
|--|----------------|-------|-----|
| Name of business/individual requesting reimbursement | Street Address | | |
| | City | State | Zip |

| | |
|-----------|------|
| Signature | Date |
|-----------|------|

By signing I hereby affirm that the above information is true and accurate and that the costs were paid directly by myself/program and have not been paid by a third party.

Include the following with this form:

1. Original Receipt/s
2. WOU Substitute W-9

Note: Forms with missing information will be held for payment until information is received.

Mail forms to:

Western Oregon University
TRI/Central Coordination of CCR&R
345 N Monmouth Ave
Monmouth, OR 97361

Questions: 503-838-8008, tripayments@wou.edu

| For Business Use Only |
|-----------------------------------|
| Amount: |
| Invoice #: |
| Index #: |
| Account Code: |
| Approved by: |
| Not to exceed \$250 p/year |

