Return to: Attention: Danielle Fagen Athens County Children Services P.O. Box 1046 Athens, OH 45701	Foster Parent: _____ Month/Year: _____ Name of Foster Child(ren): _____ _____ Caseworker: _____

PAYMENT FOR CARE

RATES

AGE 0-3: $25/night 4-12: $24/night 13-18: $26/night Beeper: $8/night

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Number of days _____ X Rate _____ = $_____

Number of days _____ X Rate _____ = $_____

Number of days _____ X Rate _____ = $_____

Number of days _____ X Rate _____ = $_____

Number of days _____ X Rate _____ = $_____

TOTAL AMOUNT REQUESTED = $_____

Comments: _____
_____
_____

_____
Foster Parent Signature

NOTE: This billing form must be completed and returned to the agency by the **first working day of the month** in order to receive reimbursement by the end of the current month.