Rhode Island Department of Human Services
Office of Child Care – Child Care Assistance Program (CCAP)
25 Howard Avenue, Louis Pasteur Building #57, 1st Floor, Cranston, Rhode Island 02920

CCAP Backbilling Request Form

Please note: Backbilling will not be accepted past 90 days of the service date.

Date	**Certificate Number (one per form)**

CCAP Provider ID	**Provider/Program Name**

Instructions:

1. Fully complete this form. Only one certificate number per form.
   - Enter "**P**" if the child attended care for some part of the weeks listed.
   - Enter "**A**" to indicate the child was absent. Absences for up to four (4) consecutive weeks will not impact payment. Anything past this will require the *Special Circumstances Absent Notice Form* included with this request documenting a special circumstance (e.g., extended illness/hospitalization).
   - Enter "**U**" or "**D**" for an upgrade or downgrade, respectively, and include the hours category being requested: full-time, three-quarter time, half time, quarter time.
2. Attach the sign in/sign out sheets for requested weeks.
3. Attach the parent-provider agreement.
4. Submit to **DHS.CCAPBilling@dhs.ri.gov**.

Week MM/DD/YY	**Child First and Last Name**	**Date of Birth**	**Attendance Status**

I certify that the information reported on this form is true and accurate.

Provider Printed Name _____

Provider Signature _____ **Date:** _____