

Benton County Human Services
ARPA Program to Support Benton Family Child Care Providers
Invoice

Daycare Provider Name: _____

Mailing Address: _____

I am requesting the following reimbursement.

_____ Up to **\$75** reimbursement for **current providers** for CPR/First Aid training registration fees. (Provide original receipt for training.) ****All receipts must be dated between 6/15/22 and 12/15/24.***

Date of Registration Fee Paid	Title of Training	License Holder Name	Total
Total Requested (max \$75 per license holder)			\$

Subscribed and sworn before me, the above report is true and correct according to the best of my knowledge and belief.

 Provider Signature:

 Date:

 For BCHS office use only:

 BCHS Approval Signature:

 Date:

Effective 6/15/22 to 12/15/24, or until all funds are exhausted, whichever comes first.

RETURN TO PAM FOSS

P.O. Box 740, Foley, MN 56329 OR pfoss@co.benton.mn.us