



Extraordinary Absence Reimbursement Request Form

Each child is allowed a maximum of 3 absences per calendar month. A request for an additional 7 absences per month may be made for extraordinary circumstances as approved by the Coalition. All absences beyond 3 days must be submitted in writing to the Early Learning Coalition for approval. **Submission of this form or letter does not guarantee payment for extraordinary absences.** Incomplete and/or unsigned forms will not be accepted for reimbursement. Written documentation from the parent must be provided for each absence. **Please attach documentation, i.e. Doctor's note, court papers, obituary notice, military papers.**

Child's Name: _____ ID / SSN#: _____

Parents Name: _____ Care Provider : _____

Required Parent Signature: I understand my provider is requesting payment for days of extraordinary absence for my child. I am aware that I can lose my school readiness subsidy and/or be prosecuted for fraud if I provide false information. Signature of Parent: _____ Date: _____

ABSENCE DATE: _____

CHECK REASON FOR EACH ABSENCE PERIOD

- Hospitalization of child or parent
- Illness requiring home-stay
- Death in immediate family
- Court order visitation
- Unforeseen military deployment
- Other special circumstance (please explain below)

Explanation of Absence(s): _____

_____ **Parent's Signature** _____

ABSENCE DATE: _____

CHECK REASON FOR EACH ABSENCE PERIOD

- Hospitalization of child or parent
- Illness requiring home-stay
- Death in immediate family
- Court order visitation
- Unforeseen military deployment
- Other special circumstance (please explain below)

Explanation of Absence(s): _____

_____ **Parent's Signature** _____

Printed Name of Facility: _____
Authorized Director Signature: _____

How to submit this form: Attach this form to your monthly attendance sheet that has the absence noted to the Coalition. Questions? Contact your Reimbursement Specialist.

For Coalition Staff Only: _____ Approved _____ Disapproved
Reason not approved: _____
Authorized Reviewer: _____ Date: _____