



State of Rhode Island and Providence Plantations  
**Rhode Island Department of Children, Youth and Families**

**Request for Babysitting Reimbursement Attestation**

*Foster families may use the form below to request reimbursement for child care expenses related to COVID 19, incurred from April 1, 2020 to April 30, 2020, that are not covered through unemployment assistance. Requests for reimbursement must be made no later than May 15, 2020. Approved reimbursement will be made in alignment with average CCAP rates. Extenuating circumstances will be reviewed on a case by case basis. Completed forms will be processed within two weeks. Incomplete forms or forms with duplicate information may result in a delay.*

\_\_\_\_\_  
 Foster Parent's Name – both if applicable

\_\_\_\_\_  
 Foster Family Home Address

\_\_\_\_\_  
 Name(s) of Foster Child(ren) – please list all

**During the COVID 19 crisis:**

- I paid for a babysitter because I had to continue working, and my DCYF funded child care provider or school was not available.  
 I paid for a babysitter because of a non work related reason. Please specify:

I am considered an essential employee during the COVID-19 crisis.

If so, what category are you considered an "essential employee"?

- |  |   |
|--|---|
| <input type="checkbox"/> Health Care, Emergency Services and/or First Responders | <input type="checkbox"/> Public Health or Government              |
| <input type="checkbox"/> Public Works (energy, water, sewer etc.)                | <input type="checkbox"/> Retail Grocery or Retail Health/Pharmacy |
| <input type="checkbox"/> Transportation  | <input type="checkbox"/> Community Based contracted providers     |
| <input type="checkbox"/> Other (please specify):                                 |   |

Name of Person Who Provided Babysitting (first and last)	Phone Number of Person Who Provided Babysitting	Date Babysitting was Provided	# of Hours Babysitting was Provided	Amount that was paid for Babysitting
		4 /    / 2020		\$
		4 /    / 2020		\$
		4 /    / 2020		\$
		4 /    / 2020		\$
		4 /    / 2020		\$

**BY SIGNING THIS FORM, YOU ARE ATTESTING THAT THE EXPENSES LISTED ON THIS FORM ARE ACCURATE AND COMPLETE FOR BABYSITTING RELATED TO COVID 19.**

\_\_\_\_\_  
*Signature of Foster Parents*  
 (electronic signature is acceptable)

\_\_\_\_\_  
 Date

<b>OFFICE USE ONLY</b>	Provider ID: Agency:	Amount Approved:	Amount Denied:	Signature Date
----------------------------	-------------------------	------------------	----------------	-------------------