CHICAGO DEPARTMENT OF CHILDREN & YOUTH SERVICES
CHILD CARE BILLINGS TRANSMITTAL SHEET

DELEGATE AGENCY NAME: _____

Instructions: List all billings individually. This transmittal sheet is not considered proof of submission if it is not stamped and initialed by CYS staff.

			Check one only		
ACTIVITY #	**MONTH/YEAR**	**FUND #**	**ORIGINAL**	**SUPPLEMENT**	**AMOUNT BILLED**

FOR CYS STAFF USE ONLY

Received and initialed by: _____