Department of Human Services
Division of Family Development
Office of Child Care Operations
ECC Attendance Log

Name of CCR&R 4CS of Passaic County, Inc						County Passaic County	
Provider Name:						EPPIC #	
Site/Location Address:						Phone	
Child's Name:						Case #	
Check One	☐ **WFNJ**		☐ **NJCK**		☐ **CPS or PACC**		
Instruction – This attendance log is a backup form and specific to ECC. Please note – this form <u>does not</u> replace parents' requirements for daily checking in and out their child(ren) using the ECC system. Send to the CCR&R along with the payment discrepancy form immediately when information was not properly recorded in ECC.							
Week of	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Check-In							
Check-Out							
Week of							
Check-In							
Check-Out							

I CERTIFIED THIS IS AN ACCURATE ACCOUNT OF ATTENDANCE FOR THE CHILD REFERENCED ABOVE

Both the Parent and Provider must sign and date below

Parent's/Guardian Signature	Date:
Provider's Signature	Date:

Comments

4CS of Passaic County, Inc. * 2 Market St, 3rd Flr. * Paterson, NJ 07501
V:973.684.1904 * F: 973.684.0468

New Jersey Department of Human Services
Division of Family Development
Office of Child Care Operations

E-Child Care Provider Payment Discrepancy Form

County: Passaic **Date:** _____

Name of Provider: _____ **EPPIC ID Number:** _____

Provider's Address: _____

Telephone: _____ **New address and/or phone number: Y/N**

☐ **POS User** ☐ **IVR User**

Please complete and submit Proof of Attendance

Please complete and write reason or any additional information you think we will need.

*I was **not paid** accurately or **at all** for the child(ren) listed below on the date indicated below:*

Child's Name	Child's ID	Date(s)	FT or PT

Comments (i.e indicate amount paid):

Provider Signature: Date:

Child Care Resource and Referral Finding and Action Taken

Verified information in EPPIC Y/N **Other:** _____
Checked Agreement in Source System Y/N _____
Reviewed Attendance Log Y/N

Outcome of Finding and/or Action Required

Adjustment Made in AT _____ **No Discrepancy Found** _____
Manual Claim Required _____ **Other:** _____

Staff Signature

Supervisor's Approval

Date Provider Notified

Please fax or mail this form immediately to your CCR&R. Please allow a minimum of 5 days to research your problem and contact you. (4CS OF PASSAIC COUNTY, INC. * 2 MARKET ST. 3RD Flr. * Paterson, NJ 07501) V:973.684.1904 F:973.684.0468