Below are three different versions of the *Just in Time Care* Invoice Form.

Each employer has specific policies and therefore you need to use a specific version of the *Just in Time Care* (JITC) Invoice.

- **Form A is designed for JITC clients whose employer ONLY allows subsidy reimbursed to the employee.**
- **Form B is designed for JITC clients whose employer allows employees to choose whether their subsidy money is sent to their backup care provider, or whether the money is reimbursed to the employee.**
- **Form C is for JITC clients whose employer ONLY permits the subsidy funds to be sent to the backup care providers.**

If you have any questions about the type of *Just in Time Care* service that your company offers, please refer to your Enrollment Packet or call JITC at 800-537-5557 or 302-479-5101.

Complete a JITC invoice after the care takes place and sign it. In most cases it also needs to be signed by your provider. There is an exception for Form A. Please read the details in your Enrollment Packet.

E-mail, mail, or fax invoices to *Just in Time Care* at Children & Families First.

Children & Families First
555 Justison St.
Wilmington, DE 19801
Phone: 800-537-5557 or 302-479-5101
Fax: 855-462-0426
E-mail: jitc@jitc.org

JUST IN TIME CARE® INVOICE FOR SERVICES PROVIDED
FORM A

Submitted Invoice must be signed by the employee **after care is completed.**

****Important: please print clearly. If information is not readable, it will result in delay of payment.****

Invoice must be submitted by the last day of the month following the month in which care occurred or your invoices will not be paid.

Employee and Care Information

Employer	
Employee Name	
Employee ID Number (required)	
Work Email (required)	
Employee Work Telephone #	
Type of Care *(check one)*	___ Well Care ___ Sick Care
Reason for Care *(check one)* ___Child sick ___Adult/elder sick ___Adult/elder transition ___Business travel ___Evening/weekend business event ___Overtime	School closing: ___Scheduled ___Weather-related Provider: ___Sick ___Vacation ___Quits/closes ___Emergency
Dates of Care	
Hours of Care	
Dependent Name, Birthdate, and Relation to Employee	
Dependent Name, Birthdate, and Relation to Employee	
Cost of Care Paid by Employee	$
Subsidy to Be Paid *(100% of cost up to $50 per day)**	$

Employee: I hereby certify that the information listed on this invoice is correct, and that the use of this care is work-related and short-term. I also certify that this provider meets the following requirements: is 16 years of age or older; is not my spouse/partner, my child's parent, my adult/elder's child, my adult/elder's spouse; or a member of my household, and is not my regular care provider, unless being used for additional backup hours beyond the normal care schedule.

I accept responsibility for payment of services rendered if not eligible for subsidy from the *JITC program*.

Employee Signature_____________________________________

**Amount to be paid is based on employer subsidy level, amount of days remaining in employee's subsidy account, and any other guidelines set by the employer.*

Provider Information

Provider Name	
	Check 1 Type of Care
Type of Care ***MUST SUBMIT RECEIPT WITH INVOICE.*** ***Provider's Signature Not Required***	___ Center ___ Family Child Care ___ In-home agency ___ Other: _________________
Type of Care ***MUST HAVE PROVIDER's SIGNATURE.*** ***Receipt Not Required***	___ Family *(relation to employee:___________)* ___ Friend ___ Other: _________________

Friend & Family Provider: I certify that I provided care to the dependents listed for the hours shown. In signing this invoice, I certify that I meet the *Just in Time Care* requirements (see bottom of first column), including that if I am a family member I do not live in the same household as the dependent I cared for. The information given by me under the *JITC* program is correct.

Friend & Family Provider Signature____

Employee: Checks will be mailed to the Employee's home address on file with the *Just in Time Care* program. If you have moved since the last time you used JITC please contact JITC before submitting the invoice to update your address.

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Wilmington, DE 19801

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Fax: **855-462-0426**
Email: **jitc@jitc.org**
Website: **jitc.org**

JUST IN TIME CARE® INVOICE FOR SERVICES PROVIDED

FORM B

Invoice must be signed by the employee and the provider **after care is completed.**

<u>Important: please print clearly. If information is not readable, it may result in delay of payment.</u>

All invoices must be submitted no later than two months past the conclusion of your plan year for care that occurred the previous year, or your invoices will not be paid.

Employee and Care Information

Employer	
Employee Name	
Employee ID #	
Employee Work Telephone #	
Type of Care *(check one)*	___ Well care ___ Sick care
Reason for Care *(check one)* ___Child sick ___Adult/Elder sick ___Adult/Elder transition ___Transition care for self ___Business travel ___Evening/weekend business event ___Overtime	School closing: ___Scheduled ___Weather-related Provider: ___Sick ___Vacation ___Quits/closes ___Emergency
Dates of Care	
Hours of Care	
Dependent Name, Birthdate, and Relation to Employee	
Dependent Name, Birthdate, and Relation to Employee	
Full Cost of Care	$
Less Employee Portion of Cost	$
Subsidy to Be Paid*	$

Employee: I hereby certify that the information listed on this invoice is correct, and that the use of this care is work-related and short-term. I also certify that this provider meets the following requirements: is 19 years of age or older; has provided a social security # or tax ID #; is not my spouse/ partner, my child's parent, my adult/elder's child, or my adult/elder's spouse; and is not my regular care provider, unless being used for additional backup hours beyond the normal care schedule.

I accept responsibility for payment of services rendered if they are not reimbursed by my *JITC* account.

Employee Signature____

**Amount to be paid is based on employer subsidy level, amount of money remaining in employee subsidy account, and any other guidelines set by the employer.*

Provider Information

Provider Name *(as it should appear on check)*	
Type of Care *(check one)*	___ Center ___ Family child care business ___ In-home agency ___ Family *(relation to employee:___________)* ___ Friend ___ Other: ________________
Provider Telephone #	
Social Sec. # or Tax ID #	

Provider: I certify that I provided care to the dependents listed for the hours shown. In signing this invoice, I certify that I meet the *Just in Time Care* requirements (see bottom of first column), and that the information given by me in applying for payment under the *JITC* program is correct.

Care Provider Signature____

Note to employee: *If your provider prefers receiving the full cost of care at the time of care,* Just in Time Care *can reimburse you the employer subsidy portion. Below, indicate whether the check is to be sent to you or your provider.*

____Send payment to employee ____Send payment to provider

Make check payable to:

Street address:

City:

State: Zip:

___*check here if this is a new address*

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jitc.org

JUST IN TIME CARE® INVOICE FOR SERVICES PROVIDED
FORM C

Invoice must be signed by the employee and the provider **after care is completed.**

****<u>Important: please print clearly. If information is not readable, it may result in delay of payment.</u>****

All invoices must be submitted no later than two month past the conclusion of your plan year for care that occurred the previous year, or your invoices will not be paid.

Employee and Care Information

Employer	
Employee Name	
Employee ID #	
Employee Work Telephone #	
Type of Care *(check one)*	___ Well Care ___ Sick Care
Reason for Care *(check one)* ___Child sick ___Adult/Elder sick ___Adult/Elder transition ___Business travel ___Evening/weekend business event ___Overtime	School closing: ___Scheduled ___Weather-related Provider: ___Sick ___On vacation ___Quits/closes ___Emergency
Dates of Care	
Hours of Care	
Dependent Name, Birthdate, and Relation to Employee	
Dependent Name, Birthdate, and Relation to Employee	
Full Cost of Care	$
Less Employee Portion of Cost	$
Subsidy to Be Paid*	$

Employee: I hereby certify that the information listed on this invoice is correct, and that the use of this care is work-related and short-term. I also certify that this provider meets the following requirements: is 19 years of age or older; has provided a social security # or tax ID #; is not my spouse/ partner, my child's parent, my adult/elder's child, or my adult/elder's spouse; and is not my regular care provider, unless being used for additional backup hours beyond the normal care schedule.

I accept responsibility for payment of services rendered if they are not reimbursed by my *JITC* account.

Employee Signature____

**Amount to be paid is based on employer subsidy level, amount of money remaining in employee subsidy account, and any other guidelines set by the employer*

Provider Information

Provider Name *(as it should appear on check)*	
Type of Care *(check one)*	___ Center ___ Family child care business ___ In-home agency ___ Family *(relation to employee:___________)* ___ Friend ___Other: _______________
Provider Address *___ check here if this is a new address*	Street address: City: State: Zip:
Provider Telephone #	
Social Sec. # or Tax ID #	

Provider: I certify that I provided care to the dependents listed for the hours shown. In signing this invoice, I certify that I meet the *Just in Time Care* requirements (see bottom of first column), and that the information given by me in applying for payment under the *JITC* program is correct.

Care Provider Signature____

By participating in the *Just in Time Care* program, the employee agrees that neither your employer nor Children & Families First will have any liability, direct or indirect, for the actions of any particular provider or any adverse consequences that may arise in connection with the use of the *Just in Time Care* program.

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