

# CHILD CARE STIPEND FORM

FAMILY MEMBER NAME: \_\_\_\_\_

VENDOR #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

PHONE: \_\_\_\_\_ (HOME) \_\_\_\_\_ (WORK)

DATE OF MEETING: \_\_\_\_\_ MEETING TIME: \_\_\_\_\_ TO \_\_\_\_\_

Leave Home at \_\_\_\_\_  a.m.  p.m. Return to Home at \_\_\_\_\_  a.m.  p.m.

TITLE OF MEETING:  ICC Committee  ICC Subcommittee  
 OSEP Meeting  Training  
 Program Review  Task Force  
 Other: \_\_\_\_\_

SIGNATURE : \_\_\_\_\_ DATE: \_\_\_\_\_  
*Family Member*

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
*IDEA, Part C Staff*

**Important Note: Child Care Stipend Forms must have original signature in blue ink (form cannot be faxed).**

**You will receive an IRS form 1099 at the end of the year for tax purposes.**

**Completed Child Care Stipend Forms should be received by the IDEA Part C staff member no later than two weeks after meeting date. This is important for fiscal accountability. Forms received after state fiscal and grant year closures cannot be reimbursed.**

**Please return completed forms to: *IDEA Part C Office*  
*4126 Technology Way, Suite 100*  
*Carson City, NV 89706***

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*State of Nevada, Dept of Health and Human Services, Director's Office, IDEA Part C Office Personnel To Complete Below:*

APPROVED BY: \_\_\_\_\_ DATE: \_\_\_\_\_  
*IDEA Part C Coordinator*

STIPEND RATE: \_\_\_\_\_ AMOUNT OF VOUCHER: \_\_\_\_\_

BUDGET ACCOUNT: 3276 CAT#: 33 ORG#: 1121 GL#: 7190