Inclusion Support Program

Staffing Grant Payment Form

Manitoba

RESET FORM

This form must be received no later than ten (10) working days following the end of the billing period or payment may not be provided.

A • Facility Information

Incorporated Name	Facility Number
Address	
City or Town	Postal Code

B • Billing Period

From :	To:
Days Open †	In-Service Days

† Days open per 4 week billing period including statutory holidays.

C • Staffing Grant Requested

Name of Child	Date of Current Individual Program Plan	Date of Enrolment or Withdrawal (if this period)	No. of Days Attended* (Regular)	No. of Days Attended* (Variation)	(A) Actual Inclusion Support Program Staff Hours	(B) Approved Salary per Hour	(C) Total Salary (A x B)	(D) Employer Benefits In Dollars	(E) Total (C + D)
							0.00		0.00
							0.00		0.00
							0.00		0.00
							0.00		0.00
							0.00		0.00
							0.00		0.00
							0.00		0.00
							0.00		0.00
Grand Total									0.00

* As requested on the staffing grant application.

D • Authorization

☐ I hereby certify that the above information is accurate.

Director or Provider	Date

E • FOR OFFICE USE ONLY

I hereby certify that the above information is accurate. ☐	Child Care Coordinator	Date

Text	Vendor No.	Cost Element	Order No.	Ref Doc.
Inclusion Staffing Grant		7211000		

Approval for Payment	Date	Amount Payable by Province ➤	0.00

Email your completed form to **your Child Care Coordinator**. Save a copy for your records.

Rev. 06/17