Dove Healthcare

Childcare Voucher Plan
Corporate Payment Request Form

Date of Request: _____ Facility: _____

Employee Name:_____

Childcare Provider Name: _____

Childcare Provider Address: _____

Childcare Provider Phone Number:_____

Childcare Provider Federal Tax ID Number: _____

(Please provide SSN if you are a non-licensed provider)

Certificate of Eligibility

By signing below, I certify that the above named individual's child(ren), as listed below, were provided childcare services during the dates of service noted.

_____ _____
Provider Signature Title/Position

_____
Employee Signature

Calculation of Corporate Payment Request

Full Name of Child	Rate Per Week/Month	Total Childcare Expense	HR Calculated %	Dates of Service __/__/____ To __/__/____

**As of April 1, 2025, Dove Healthcare's childcare assistance will be 20% of total monthly cost, up to $320 / per child.

Please mail or fax this form to:
Dove Healthcare
Attn: Human Resources
2815 County Hwy I
Chippewa Falls, WI 54729
Fax Number: (715)726-3856
Phone: (715)723-9348, ext. 1265

Monthly charges must be submitted by the 15th of the following month in order to be paid. If received after this time, payment is not guaranteed.

Vendor Number		Invoice Date	
Invoice Number		Approved By:	
Account		Amount	
6900-71500			
Scanned	Total:		