



ACT Government Claim for Payment

Application Reference Number			
Service Name			
Address			
ABN		CCMS ID	

Description of Service Provided		
Quantity (in hours)	Subsidy Amount	Total (hours x \$16.19)
	\$16.43 per hour	
	GST 10%	
	Total Amount Payable	

Please briefly describe the outcomes achieved:

I, the child care service representative, verify that this funding was used to support the inclusive practices of our service as stated in the funding application.

Name: _____ Signature: _____ Date: _____

Once this form is completed it becomes a TAX INVOICE, please retain a copy for your records.

Office Use Only			
Total hours requested	x Hourly rate	+ GST 10%	= Total Entitlement
Delegate Name		Cheque No/DD	
Delegate Position		Date	
Delegate Signature		Amount	
		Prepared By	
Date		Authorised By	