R003

Colorado Department of Human Services
Trails System Report
Division of Child Welfare
OOH Main Provider Roster
For Service period

Month:_____ **Year**:_____

County: 35 Larimer

Governing Body / Provider Name:
***Update information on services from Larimer County**

Email to:
hs-fostercare-accounting@co.larimer.co.us

Provider Name:

Address:

Provider ID:

To arrive prior to next payroll period:

Service Type:

Service Category:

Child's Name Case ID	State ID	Sex	Birthday	Worker Name	Dates of Service	No Days/ Units	Amount
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		

I certify that care was provided for the children listed above for the dates specified.

(Signature) (Date)

(Email)