



# BEAUFORT

COUNTY COMMUNITY COLLEGE  
Office of Financial Aid

5337 Highway 264 East  
Washington, NC 27889  
T: 252.940.6222  
F: 252.940.6393  
finaid@beaufortccc.edu

## Childcare Grant Invoice

Date: \_\_\_\_\_

**To be completed by Childcare Provider**

Name of Childcare Provider: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: (\_\_\_\_\_) \_\_\_\_\_ Federal ID: \_\_\_\_\_

**Reference:**

Name of Student/Parent: \_\_\_\_\_ Student ID: \_\_\_\_\_

Name of Dependent(s): \_\_\_\_\_

Period Covered: \_\_\_\_\_ through \_\_\_\_\_  
Month/Day/Year Month/Day/Year

<b>Total Amount Due:</b>	<b>\$</b>
*Cannot pay in advance; only report period for which services have been rendered	

<b>TO BE COMPLETED BY BCCC FINANCIAL AID OFFICE</b>	
Student Credit Hours Enrolled	
Total Amount of Invoice	<b>\$</b>
Total Balance Due from Parent	<b>\$</b>
Total Amount Approved to pay for period covered by BCCC	<b>\$</b>

**Certification & Signatures**

Each signature below certifies that this information is true and correct.

\_\_\_\_\_  
Student/Parent Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Daycare/Childcare Provider-Print Name & Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
BCCC Childcare Coordinator Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Financial Aid Director Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Vice President of Administrative Services Signature

\_\_\_\_\_  
Date