RE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Print Applicant’s Name)

The person referenced above is a participant in a federally-assisted housing program. Federal regulations require that we verify expenses paid for the care of dependent children enabling the family member to be employed or to attend school. The amounts provided must be paid out-of-pocket by the participant and may not be reimbursed for another source. Please complete all the information below. Thank you for your assistance.

By signing below, I authorize the release of this information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant’s Signature Date

I certify that I provide child care services for the above-referenced participant and receive the amount of compensation stated. Date you began services: \_\_\_\_\_\_\_\_\_\_\_\_\_ Number of hours provided each day: \_\_\_\_\_\_\_\_\_\_\_\_\_. Names of children for which child care is provided:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name |  | Age |  | Name |  | Age |  |
| Name |  | Age |  | Name |  | Age |  |

Do you receive co-payments from the state or any other source for this participants’ child care? [ ] Yes [ ] No

If yes, Base Amount $\_\_\_\_\_\_\_\_\_\_ Participant Portion: $\_\_\_\_\_\_\_\_\_\_\_ Co-Payment Portion: $\_\_\_\_\_\_\_\_\_\_\_\_\_

I receive $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ each ***week*** for services **OR** I receive $\_\_\_\_\_\_\_\_\_\_\_\_\_ each ***month*** for services.

I certify that this information is accurate.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Name (print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City State Zip

Title or relation to participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please return form to: Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Attn: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

**WARNING: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful, false statements of misrepresentation to any department or agency of the United States or to any matter within its jurisdiction.**