VERIFICATION OF DEPENDENT CARE EXPENSES

DCF Office Address/FAX #:

Date:____________________

Case Name:____

Case Number:_______________________________

Please fill out this form to show how much you charge for taking care of children or disabled persons for: ____ and return the form to us by _________________________.

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1. Please Check **A** or **B**:

   A. ☐ I take care of a child or a disabled person for (name) ___________________________________. I started taking care of this child or disabled person on (date) _________________________.

   B. ☐ I stopped taking care of a child or disabled person for (name) ___________________________________ on (date) ____________________________.

2. Please fill out this part about each child or disabled person that you have taken care of for the last four weeks (month). Please do **not** write in **past due** amounts.

Child or Disabled Person:	**Name:**	**Name:**	**Name:**	**Name:**
Amount paid each week or month	**Date:** **Amount: $**	**Date:** **Amount: $**	**Date:** **Amount: $**	**Date:** **Amount: $**
	Date: **Amount: $**	**Date:** **Amount: $**	**Date:** **Amount: $**	**Date:** **Amount: $**
	Date: **Amount: $**	**Date:** **Amount: $**	**Date:** **Amount: $**	**Date:** **Amount: $**
	Date: **Amount: $**	**Date:** **Amount: $**	**Date:** **Amount: $**	**Date:** **Amount: $**

What I have written on this form is true. I know if I write amounts that are not true, on purpose, I could get charged with fraud.

Sign Here:____ Date:__________________________________

Business Name:____ Relationship:___________________________

Address:____ Telephone Number:_______________________