Clear

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 <u>each</u> 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:_____