ACCT. #_____

CHILD CARE EXPENSES VERIFICATION

I GIVE MY PERMISSION TO RELEASE REQUESTED INFORMATION REGARDING CHILD CARE EXPENSES TO THE WHITE PLAINS HOUSING AUTHORITY

_____ _____

Resident Signature ***Date***

THIS IS TO VERIFY THAT CHILD CARE IS PROVIDED FOR: _____

Parent/Guardian Name

Name of Child/Children:_____

INFANTS TO 5 YRS. ONLY

⇒ at the rate of $_____ per week

⇒ at the rate of $_____ per week

COMPLETE BELOW ONLY IF CHILD IS ON AN IRREGULAR BASIS

6 – 13 YRS. ONLY

⇒ at the rate of $_____ per wk. during school year specify # wks._____

⇒ at the rate of $_____ per week during school vacation

Date Service Began_____ Terminated Yes____ No____

CHILD CARE AGENCY (Stamp)

_____

_____

_____

_____

Telephone#:_____

_____

Authorized Signature

Date:_____

PRIVATE IN-HOME DAY CARE

Provider's Name_____

Please print

ARE YOU LICENSED? ( ) Yes ( ) No

SSN:_____

Address:_____

_____

***MUST BE ABLE TO SUBSTANTIATE DAY CARE CLAIM via YEAR END TAX REFUND STATEMENT**