

HEAD OF HOUSEHOLD NAME	SOCIAL SECURITY NUMBER (last 4 digits)
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**FORM 10. VERIFICATION OF CHILDCARE EXPENSES**

Households who have un-reimbursed childcare expenses should complete this form if: <input type="radio"/> The expenses are for a child or children age 12* or younger <u>and</u> <input type="radio"/> The childcare is necessary for a family member to be gainfully employed or to further his or her education.  <b>THIS FORM MUST BE COMPLETED BY THE HEAD OF HOUSEHOLD AND COMPLETED AND SIGNED BY THE CHILDCARE PROVIDER.</b>	<b>Have you completed this form?</b>	
	Yes <input type="checkbox"/>	Not Applicable <input type="checkbox"/>

Name of Child	Age of Child	Rate of Pay During School Year	Rate of Pay During School Vacations	Frequency of Pay (hourly, daily, weekly, monthly, annually)	Monthly Average
		\$	\$		\$
		\$	\$		\$
		\$	\$		\$
		\$	\$		\$
		\$	\$		\$

If childcare expenses are seasonal, sporadic, or cannot be accurately captured in the above chart, please explain: \_\_\_\_\_

Name of Childcare Provider: \_\_\_\_\_ Address: \_\_\_\_\_  
 Contact: \_\_\_\_\_ Title: \_\_\_\_\_ Telephone (Required): \_\_\_\_\_

\*If child is 13 or older, disabled, and care for child enables an adult household member to be employed, please complete "Verification of Un-Reimbursed Disability Expenses" (Form 7).

I certify that the above information is accurate and understand that providing false statements to a government agency is punishable under federal law.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 SIGNATURE OF CHILD CARE PROVIDER DATE

**FOR HPD USE ONLY**

Call to provider made on \_\_\_\_\_ (date) by \_\_\_\_\_ staff member's name

Expenses verified?  Yes  No Notes: \_\_\_\_\_