

VERIFICATION OF AMOUNT PAID FOR CARE OF CHILDREN OR DEPENDENT PERSON(S)

I, _____ of _____
Business Address

_____, do hereby certify I provide childcare on the
below days for the hours indicated for the following children:

_____.

Days (check as required):

☐	Mon	Hours – From: _____	AM/PM to _____	AM/PM
☐	Tue	Hours – From: _____	AM/PM to _____	AM/PM
☐	Wed	Hours – From: _____	AM/PM to _____	AM/PM
☐	Thu	Hours – From: _____	AM/PM to _____	AM/PM
☐	Fri	Hours – From: _____	AM/PM to _____	AM/PM
☐	Sat	Hours – From: _____	AM/PM to _____	AM/PM
☐	Sun	Hours – From: _____	AM/PM to _____	AM/PM

Total hours per week: _____ Total hours per month: _____.

Amount received for care from the family: \$ _____ ☐ week, ☐ month.

Amount received for care from others (if any): \$ _____ ☐ week, ☐ month.

Estimated cost of care for the next 12 months: \$ _____. (Include full-time summer care of school children, if applicable).

Social Security Number/Tax-ID

Signature of Day Care Provider

Telephone Number

NOTARY PUBLIC

Relationship to parent, if any

Signed, the _____ day of _____, 20_____

In the presence of _____
Notary

Please note that you can ask for a reasonable accommodation to use HAPGC housing or services. This can include auxiliary aids or services, materials in an alternative format, or help in completing paperwork or changes to your housing based on your disability. Contact the 504 Coordinator at (301)883-5576 or email dhcd-504@co.pg.md.us for assistance.

