



# 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 \_\_\_\_\_.

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:	Date:	Date:	Date:
	Amount: \$	Amount: \$	Amount: \$	Amount: \$
	Date:	Date:	Date:	Date:
	Amount: \$	Amount: \$	Amount: \$	Amount: \$
	Date:	Date:	Date:	Date:
	Amount: \$	Amount: \$	Amount: \$	Amount: \$
	Date:	Date:	Date:	Date:
	Amount: \$	Amount: \$	Amount: \$	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: \_\_\_\_\_