

Home Forward * Rent Assistance Department Verification of Child Care or Attendant Care Costs

Care Provider: Please complete the following information for all children age 12 and younger for whom you provide care. A release of information form is attached, authorizing us to receive this information.

Head of Household:

I, _____ do hereby certify that I/we provide care on the following days for the hours indicated for the following children or dependent persons:

Name of Dependent	Age	Check Days Cared for								Hours: Start	End
		<input type="checkbox"/> M	<input type="checkbox"/> T	<input type="checkbox"/> W	<input type="checkbox"/> Th	<input type="checkbox"/> F	<input type="checkbox"/> S	<input type="checkbox"/> Su			
		<input type="checkbox"/> M	<input type="checkbox"/> T	<input type="checkbox"/> W	<input type="checkbox"/> Th	<input type="checkbox"/> F	<input type="checkbox"/> S	<input type="checkbox"/> Su			
		<input type="checkbox"/> M	<input type="checkbox"/> T	<input type="checkbox"/> W	<input type="checkbox"/> Th	<input type="checkbox"/> F	<input type="checkbox"/> S	<input type="checkbox"/> Su			
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		<input type="checkbox"/> M	<input type="checkbox"/> T	<input type="checkbox"/> W	<input type="checkbox"/> Th	<input type="checkbox"/> F	<input type="checkbox"/> S	<input type="checkbox"/> Su			
		<input type="checkbox"/> M	<input type="checkbox"/> T	<input type="checkbox"/> W	<input type="checkbox"/> Th	<input type="checkbox"/> F	<input type="checkbox"/> S	<input type="checkbox"/> Su			

Date children began receiving care:

Total hours: _____ per week or per month

Cost of care to family: \$ _____ per week per month

Amount paid by family: \$ _____ per week per month

Does anyone else pay you for these children's care? Yes No

• If yes, who? Welfare Other:

• If yes, amount paid: \$ _____ per week per month per year

Estimated cost of care for the upcoming 12 months for these children: \$ _____

WARNING! Title 18, Section 1001 of the United States Code, states that a person who knowingly and willingly makes false or fraudulent statements to any department or agency of the United States is guilty of a felony.

Signature: _____ Date: _____

Full Address: _____ Phone: _____

Relationship to family (if any): _____

Return to: Home Forward, Shelter Plus Care, 135 SW Ash St., Portland, OR 97204.

You may also fax to: (503) 802-8330.

If you have questions, please contact _____ at _____