ABILENE HOUSING AUTHORITY
1149 E South 11th Street
Abilene, TX 79601

Please fax response to:
325-676-6375
Counselor: _____

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

I hereby authorize the release of the information requested below.

Head of Household Printed Name	Head of Household Signature	Date
_____	_____	_____

Childcare Provider Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

DO NOT WRITE BELOW THIS LINE

(To be completed by the Child Care Provider)

Child/Children cared for:

Name	*Age*	*Name*	*Age*
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Total hours child/children are cared for per week: _____

Amount received for care from the family: $ _____ per ☐ week ☐ month

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

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

Provider Printed Name	Title
_____	_____

Provider Signature	Date
_____	_____

WARNING: Title 18, Section 1001 of the U.S. Code State that a person is guilty of a felony for knowingly and willingly making false of fraudulent statements to any Department of the United States government. Also, amounts received from providing childcare are reportable to the Internal Revenue Services (IRS).