



Jessica G. Anderson-Preston, Executive Director

Yolanda L. Hawkins-Bautista, Chair – Board of Commissioners

### 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):

<input type="checkbox"/>	Mon	Hours – From: _____	AM/PM to _____	AM/PM
<input type="checkbox"/>	Tue	Hours – From: _____	AM/PM to _____	AM/PM
<input type="checkbox"/>	Wed	Hours – From: _____	AM/PM to _____	AM/PM
<input type="checkbox"/>	Thu	Hours – From: _____	AM/PM to _____	AM/PM
<input type="checkbox"/>	Fri	Hours – From: _____	AM/PM to _____	AM/PM
<input type="checkbox"/>	Sat	Hours – From: _____	AM/PM to _____	AM/PM
<input type="checkbox"/>	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

\_\_\_\_\_  
Relationship to parent, if any

NOTARY PUBLIC

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](mailto:dhcd-504@co.pg.md.us) for assistance.*

