The Housing Authority of the City of Aiken Housing Authority
P.O BOX 889 AIKEN, SC 29803
PHONE#: (803) 649-6673 FAX: (803) 643-0069

CHILD CARE EXPENSES VERIFICATION

Organization or Institution Provides Care

Re: _____ Date: _____

Dear Sir/Madam:

We are required to verify the expenses of all family members living in or applying for public housing. We ask your cooperation by supplying the information requested below about the referenced person. We will use any information you provide only to determine the family's eligibility and rent, and pledge to keep the data in strict confident.

Name (s) and age (s) of child (ren) cared for:

1. _____ _____ 4._____ _____
2. _____ _____ 5._____ _____
3. _____ _____ 6._____ _____

Child care is provided on the following days for the hours indicated:

Monday: _____hours Tuesday: _____ hours
Wednesday: _____ hours Thursday: _____ hours
Friday: _____ hours Saturday: _____ hours
Sunday: _____ hours
Total hours per week: _____ Total hours per month: _____
Cost of Care: $_____, per ____ week _____ month ____year
Estimated cost of care to the family for the upcoming 12 months: _____
_____

Name of individual or program providing child care services for this family:
_____
Address: _____
_____

_____
Signature of Childcare Provider Date

TENANT/APPLICATION RELEASE

I, _____, hereby authorize the release of the requested information.

_____
Signature Date

THIS FORM MUST BE NOTARIZED