

CHILD CARE VERIFICATION

DCSS 0069 (08/16/04)

Case Number: _____

APPLICANT NAME: _____

I am the ___ Custodial Party ___ Noncustodial Parent

APPLICANT: Give this form to your childcare provider to complete before you return it to the local child support agency. Attach any receipts or copies of canceled checks for child care.

CHILD CARE PROVIDER: Please complete the appropriate section(s) for the children of the above named applicant for whom you provide child care. Then sign and date at the end of this form.

SECTION I: INFANT & PRE-SCHOOL CHILD(REN)

Name of Provider/Day Care Center _____

Address _____

City _____ State _____ Zip _____ Phone (____) _____

Name of a person(s) who pays you for childcare _____

Name of the child(ren) of this parent for whom you provide care and the amount paid.

Child _____ Amount \$ _____ ^(Circle One) per day/week/month

Child _____ Amount \$ _____ per day/week/month

Child _____ Amount \$ _____ per day/week/month

Total: \$ _____ per day/week/month

SECTION II: SCHOOL-AGE CHILD(REN)

A. Child care provided during regular school sessions:

Name of Provider/Day Care Center _____

Address _____ Apt. or Unit No. _____

City _____ State _____ Zip _____ Phone (____) _____

Name of a person(s) who pays you for childcare _____

Name of the child(ren) of this parent for whom you provide care and the amount you receive.

Child _____ Amount \$ _____ ^(Circle One) per day/week/month

Child _____ Amount \$ _____ per day/week/month

Child _____ Amount \$ _____ per day/week/month

Total: \$ _____ per day/week/month

B. Summer/vacation care for school-age child(ren). Include amounts in the information specified below.

Name of Provider/Day Care Center _____

Address _____

City _____ State _____ Zip _____ Phone (____) _____

Name of a person(s) who pays you for childcare _____

Name of the child(ren) of this parent for whom you provide care and the amount you receive.

(Circle One)

Child _____ Amount \$ _____ per day/week/month

Child _____ Amount \$ _____ per day/week/month

Child _____ Amount \$ _____ per day/week/month

Total: \$ _____ per day/week/month

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

SIGNATURE

DATE