



**HARRISONBURG
REDEVELOPMENT AND
HOUSING AUTHORITY**

P.O. BOX 1071 + HARRISONBURG, VA 22803
Phone/VTDD 540-434-7386 + Fax 540-432-1113

CHILDCARE VERIFICATION

Name of Head of Household	***_**_
Address	Last 4 of SSN
	Unit Number

I hereby authorize the release of the below information, relative to my childcare expenses, to HRHA.

Head of Household Signature	Date
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TO CHILDCARE PROVIDER: Thank you for completing this inquiry about the person named above, to determine eligibility and/or rent calculations for low-income housing with HRHA. Please return this form within 7 business days of receipt, by fax to 540-432-1113, or by mail to P.O. Box 1071, Harrisonburg VA 22803.

1. List the names, ages & start date of the children in your care:

Name	Age	Start Date	End Date (if applicable)

2. List the hours of the day and days of the week the children are in your care: _____
3. List the amount paid for childcare and frequency: \$ _____ per _____
4. If the rate has changed, effective date of change: _____
5. Is the amount paid to you reimbursed by an outside agency? _____ If yes, how much is reimbursed? _____
6. Any additional remarks or comments: _____

Name	Title	Date
Signature	Organization Name	Phone

WARNING: Title 18, Section 1001 of U.S. Code states that a person is guilty of a felony for knowingly and willingly making a false or fraudulent statement to any department or agency of the United States Government.

EQUAL HOUSING OPPORTUNITY PROVIDER

5/15/17