EXPENSES VERIFICATION

Submit this form with your application or recertification to verify that you pay out-of-pocket for disability-related care or childcare. **See examples below. Only submit this form if you cannot easily get receipts as proof.**

ONE FORM PER CARE PROVIDER.

Complete a separate form for each care provider, such as a preschool, daycare, babysitter, or live-in aide, who you pay out-of-pocket.

WHO COUNTS?

List children under 13 and/or someone of any age with a disability who the provider cares for, including yourself.

If you submit receipts with period, amount, and payer, do not complete this form.

APPLICANT

Please print or type. Asterisks (*) mark required responses.

Applicant's full name*
as on your social security card if you have one

Last four of your SSN
☐ *I don't have one*

Provider name*

Who does this provider care for? *full names as on their social security card if they have one*

1.

2.

YOUR SIGNATURE

By signing below, you are authorizing the provider listed above to release the information requested by DCHA.

Applicant's signature*

Date* *month/day/year*

STOP HERE, AND GIVE THIS FORM TO YOUR CARE PROVIDER.

Your care provider should complete, sign, and return the form to you. Once they do, ***submit this form with your application****.*

WHAT DO WE NEED FROM YOU?

DC Housing Authority needs to verify the expenses paid by the applicant and their household in the last 12 months. **Count 12 months from the day you sign this form.**

CARE PROVIDER

Please complete, sign, and give this form back to the applicant.

Full name* – *of the care provider or their representative*

Job title*

☐ Cell ☐ Landline

Phone number – *if you have one*

Email address – *if you have one*

Total hours of care* – *last 12 months or since care began, if less*

$ Total annual bill for care that you've provided*

$ Annual amount paid out-of-pocket - *if known*

PROVIDER SIGNATURE

By signing below, you are agreeing that the information herein is complete and correct to the best of your knowledge.

Signature*

Date* *month/day/year*