

Louisiana Department of Health

Date: _____
Name: _____
SSN: _____
Cslid/Worker: _____

CHILD CARE EXPENSE VERIFICATION

The above-named person has given consent for the release of information requested below to help establish eligibility for the Supplemental Nutrition Assistance Program (SNAP). Please complete this form and return it to us by _____. If you have any questions concerning completing this form, please call me at _____.

Sincerely,

Agency Representative

I charge and collect the following Child Care payments from _____ in **addition** to any Child Care payment that I may receive from the Child Care Assistance Program.

Child's Name	Payment Amount Billed	How Often Billed

Signature

Date

Address

Phone number where you can be reached during the day.

Address