COUNTY OF HENRICO DEPARTMENT OF SOCIAL SERVICES

P.O. Box 90775
Henrico. VA 23273-0775
Fax: (804)501-4006

Ty F Parr
Director

DAYCARE PROVIDER VERIFICATON FORM

APPLICANT'S NAME:	PROVIDER'S NAME:
ADDRESS:	ADDRESS:
PHONE:	PHONE:

I, the undersigned, authorize the following information to be given to the Department of Social Services.

Print Parent Name _____ Parent Signature _____

TO BE COMPLETED BY DAYCARE PROVIDER ONLY

Complete the following for each child or adult for which you provide care:

Name of Individual	Age in Years	Start Date	Day of the week care is provided	Hourly Rate in Dollars

Select one:

- ☐ There **was** a change in the amount of care being given after March 16th, 2020 as a result of COVID-19?
- ☐ There **was not** a change in the amount of care being given after March 16th, 2020 as a result of COVID-19?

If there was a change in care after March 16th 2020 compete the following:

Name of Individual	Date of Change	Previous Average # of Hours Per Week	New Average # of Hours Since Change	Estimated Total Impact in Dollars

What type of payment did you receive?
(Check all that apply)

- ☐ Check
- ☐ Credit Card
- ☐ Other
- ☐ Debit Card
- ☐ Cash

I certify that the information I am giving is correct. I realize that if I give incorrect information, I could be prosecuted under the law.

Printed Name of Person completing this form	Title
Signature of Person completing this form	Phone #