South Carolina Department of Social Services
Family Assistance Program

CHILD CARE PAYMENT VERIFICATION FORM

Return Form To:

_____ County DSS

_____

_____

Worker's Name: _____

Recipient's Name: _____

Case No.: _____

Case Name: _____

I certify that the above named recipient is billed $ _____

per: ❑ Week ❑ Month ❑ Other: (Explain) _____

for the following children: _____

_____

_____

Do you receive any ABC vouchers for the above named recipient/children? ❑ Yes ❑ No

I ❑ Do ❑ Do Not receive Family Independence (FI) benefits.
I ❑ Do ❑ Do Not receive Supplemental Nutrition Assistance Assistance Program (SNAP) benefits.

Name of Caregiver: (Please print) _____

Address: _____

Telephone No.: _____ Social Security No.: _____

Your Signature: _____

Date: _____