

# CITY OF BELLE GLADE VERIFICATION OF CHILD CARE EXPENSE



ATTN: HUMAN RESOURCES  
110 DR. MARTIN LUTHER KING JR. BLVD. WEST  
BELLE GLADE, FL 33430-3900  
PHONE: 561-996-0100  
FAX: 561-993-1813

TO:

CHILD CARE AGENT/AGENCY NAME

TELEPHONE NUMBER

FAX NUMBER

CHILD CARE AGENT/AGENCY ADDRESS

**CHILD(REN) INFORMATION:**

NAME

AGE

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**AUTHORIZATION:** The City of Belle Glade is required to verify expenses of all members of the household applying for participation in the First Time Home Buyer Program. We ask your cooperation in supplying this information. This information will be used only to determine applicant eligibility status.

Your prompt return of the requested information will be appreciated. A self-addressed return envelope is enclosed.

**RELEASE:** I hereby authorize the release of the requested information.

APPLICANT NAME: PRINT

SIGNATURE:

DATE:

## COMPLETION BY SERVICING AGENT/PROVIDER

Enter the amounts you received from the applicant and any other agency on behalf of the applicant.

MONTH & YEAR REPORTING	AMOUNT PAID BY APPLICANT	AMOUNT SUBSIDIZED	ARE ALL PAYMENTS CURRENT > YES / NO	IF SUBSIDIZED; HOW LONG WILL SUBSIDY CONTINUE?	COMMENTS
January 2014	\$	\$			
December 2013	\$	\$			
November 2013	\$	\$			
October 2013	\$	\$			
September 2013	\$	\$			
August 2013	\$	\$			

I declare that the foregoing information is true and correct. I understand that the City of Belle Glade will use the information I have provided for consideration of a mortgage loan.

Child Care Provider/Agency Representative Name & Date:

