NEW ROCHELLE MUNICIPAL HOUSING AUTHORITY
50 SICKLES AVENUE
NEW ROCHELLE, NY 10801
Phone: (914) 636-7050 Fax: (914) 235-1781

CHILD CARE EXPENSES VERIFICATION

I give my permission to release this requested information regarding child care expenses to the NRMHA.

Signed: _____ Date: _____

INFANT & PRE-SCHOOL CHILDREN

Name of Provider / Day Care Center _____

Address _____ Unit No. _____

City _____ State _____ Zip _____

Name of child that you provide child care for and the amounts that you receive.

Child _____ Amount $_____ per week/month/day

Child _____ Amount $_____ per week/month/day

Total $ _____

SCHOOL – AGE CHILDREN

Name of Provider / Day Care Center _____

Address _____ Unit No. _____

City _____ State _____ Zip _____

Name of child that you provide child care for and the amounts that you receive.

A. During regular school sessions:

Child _____ Amount $_____ per week/month/day

Child _____ Amount $_____ per week/month/day

B. During vacations:

Child _____ Amount $_____ per week/month/day

Child _____ Amount $_____ per week/month/day

Total $ _____

SIGN _____ DATE _____