

U.S. Department of Education

Atlanta Service Center

Declaration of Caregiver Services

I, _____ Taxpayer ID / SSN: _____ declare under penalty of law that the information I give in this statement is to the best of my knowledge and belief true, correct and complete.”

Caregiver Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Telephone Number and Area Code: _____

Customers Name: _____ pays \$ _____ dollars per Week / Month

(circle appropriate time frame) for the care of the following individual(s):

Name of Child	Age Of Child	Amount Charged Per Week / Month

Warning: 18 U.S.C. 1001 provides that “whoever...knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any materially false, fictitious, or fraudulent statement or representation...shall be fined up to \$10,000.00 or imprisoned up to five years, or both.”

Complete, sign, and return the requested information and documentation to:

**U.S. Department of Education
AWG Hearing Unit
61 Forsyth Street, Room 19T89
Atlanta, GA 30303**

I declare under penalty of law that the answers and statements contained herein are true and correct.

Signature _____
Caregiver

Date _____