

Georgia Department of Human Services

Division of Family and Children Services

CONTRIBUTION VERIFICATION

To: _____

Date:
Re: Applicant/Recipient Name

Case Number

Dear Mr./Ms.

Worker ID

The above individual has applied for assistance or is currently receiving assistance through this agency. In order to determine his/her family's eligibility for assistance, we must verify monetary contributions received from you. Please complete this form with the requested information and return it to the agency by . If you have any questions regarding this form, please call me at the number listed below.

Worker Telephone: 1-877-423-4746

I give \$ _____ per week month directly to the individual named above.

The money I give is not a loan and does not have to be paid back to me.

In the months listed below, I gave the following amounts:

Amount	Month/year
_____	_____
_____	_____
_____	_____

I pay the following bills directly to the provider for the individual named above.

Amount	Month/year	Provider's Name
_____	_____	_____
_____	_____	_____
_____	_____	_____

() I intend / do not intend to continue giving this money to the above person(s)/ provider(s)

If you **do**, please show the amount you intend to give in the future: \$ _____ every _____ (Week / Month)

If you **do not**, please show last date you gave any money: _____ .

Comments:



PLEASE READ CAREFULLY BEFORE SIGNING:

The information provided on this form reflects my total contribution. If any of this information is found to be intentionally inaccurate I may be subject to criminal prosecution for knowingly providing false information. (See Georgia Code Section 49-4-15 for the full reference.) I understand the meaning of this paragraph.

Signature of Person Completing this Form Date

Address

City State Zip Code

Telephone Number

