Georgia Department of Human Services

Division of Family and Children

Services **CONTRIBUTION**

VERIFICATION

Date:

Re:

To:

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**
_____	_____	
_____	_____	
_____	_____	

See Reverse Side

( ) 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

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