# 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 |
|---|---|---|
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**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:

**WINDHAM PROFESSIONALS**
**P.O. BOX 400**
**EAST AURORA, NY 14052**

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

Signature _____ Date _____
Caregiver