



# Lowndes County Board of Education Head Start



## INCOME VERIFICATION STATEMENT—FORM SOC SER 629B

Child's Name: \_\_\_\_\_

This is to verify that I have provided support to: \_\_\_\_\_  
*(Parent's Name)*

In the amount of \$ \_\_\_\_\_ also including shelter, food, laundry, and incidentals from:  
 \_\_\_\_\_ to \_\_\_\_\_.  
*(Date)* *(Date)*

**Certification:** I certify that this information is true. If any part is false, I understand that the above named child's participation in the program may be terminated and subject to legal action.

Supporter's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

This is to verify that my child/(ren) and I receive support during the time from: \_\_\_\_\_ to \_\_\_\_\_  
*(Date)*

\_\_\_\_\_, because of the following reason(s): \_\_\_\_\_  
*(Date)*

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Certification:** I certify that this information is true. If any part is false I understand that my child's participation in the program may be terminated and subject to legal action.

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Notary Signature: \_\_\_\_\_ Date: \_\_\_\_\_

My commission expires: \_\_\_\_\_

County of Notary: \_\_\_\_\_