

AMERICORPS PROGRAM CERTIFICATION OF ACTIVE SERVICE			
Member Name:			
Supervisor Name:			
Supervisor's Email Address:		Supervisor's Phone #: (____)-____-_____	
Service Assignment Program Name:			
Service Site Street Address:		City:	State: Zip Code:
Program Affiliation: <input type="checkbox"/> AmeriCorps State and National <input type="checkbox"/> AmeriCorps VISTA <input type="checkbox"/> AmeriCorps NCCC/FEMA		Please Check One: <input type="checkbox"/> Regular Full Time (1700 Hours of) Service. <input type="checkbox"/> Half-time, Reduced Half-time, or Quarter Time. Member is serving in: <input type="checkbox"/> Full Time Capacity <input type="checkbox"/> Part Time Capacity	
Service Term Start Date: ____/____/____		Projected Term End Date: ____/____/____	
State & National Members Only Is the member serving in the Professional Corps Program? Yes <input type="checkbox"/> No <input type="checkbox"/>		Will the member be required to complete service hours during the weekend? (*Verification of weekend service hours will be needed) Yes <input type="checkbox"/> No <input type="checkbox"/> Other* (occasionally) <input type="checkbox"/>	
AMERICORPS PROGRAM DIRECTOR CERTIFICATION			
<p><i>I certify that the Member listed above is eligible to receive child care benefits, and I certify and affirm the following:</i></p> <ul style="list-style-type: none"> ✓ I have confirmed the Member is currently an active AmeriCorps/Vista/NCCC Member. ✓ The Member will need child care services in order to serve with in this program. ✓ I certify that I will formally notify GAP Solutions in writing within five (5) business days if the Member has any interruption of their service, they end their service term early or of any other status changes that may affect the member's eligibility for child care benefits. 			
_____ AmeriCorps Program Director Name (please print)		_____ AmeriCorps Program Director Signature	
		_____ Today's Date	