ATTACHMENT J3

Department of Transitional Assistance

[Commonwealth of Massachusetts Agency Official Letterhead]

This letter certifies that _____,
(Print Name of Child)
is currently in the care/custody of the Commonwealth of Massachusetts Executive Office of Health and Human Service , **Department of Transitional Assistance.** As the signatory I, a duly authorized agency staff person attest that I have examined agency records pertaining to the above name child on:_____ the purpose of which is to verify personal information of the above named youth pertinent to a determination of eligibility for the provision of services under the Workforce Investment Act of 1998 and/or the American Recovery Reinvestment Act of 2009. The results of that examination are provided below.

Results of Documentation Examination

Date of Birth: _____

Is a citizen or legal alien of the United States	Yes	No
receives or is a member of a family that receives cash payments under a Federal, State, or local income based public assistance program	Yes	No
Is a member of a household that receives (or has been determined within the six-month period prior to the application for the program involved to be eligible to receive) food stamps pursuant to the Food Stamp Act of 1977	Yes	No

The Department understands the provision of this information shall be intended solely for the purposes of verifying information pertaining to the eligibility determination for the provision of youth services under Title I (B) (§129) of the Workforce Investment Act of 1998.

NOTE:

A notice or letter of benefits can substitute for this letter.

Please direct any questions regarding this information to:

Case Manager	
Area Office Address	
Telephone Number	

Authorized Signature: _____ Date: _____

Print Name:_____

Print Title: _____