CHILD CARE WORKFORCE BENEFIT VERIFICATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CHILD CARE ASSISTANCE
SFN 354 (1-2025)

Clear Fields

Name of Employer/Child Care Program	
Provider License Number	Tribal Provider SPACES ID or EIN

This is to certify that

Name of Employee	Employee Date of Birth
Holds the Following Position	Growing Futures Registry ID
Start Date	End Date
Position Type ☐ Permanent ☐ Temporary	Number of Work Hours per Week

As the business owner or authorized person to complete this form, I am acknowledging that the information listed above is correct. At the time the employment has ended I will notify the Child Care Assistance Program within 5 days at applyforhelp@nd.gov.

By typing my name below, I am signing this form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature. I attest, subject to the penalties of perjury that I am the individual completing this form and that I have provided accurate information.

Name of Business Owner	
Signature of Business Owner or Director	Date