## ATTACHMENT J3

## **Department of Transitional Assistance**

[Commonwealth of Massachusetts Agency Official Letterhead]

This letter certifies that				
and Human Service , <b>Depar</b> authorized agency staff personame child on: the above named youth pertonamed.	(Print Name of Child)  dy of the Commonwealth of Massachuset tment of Transitional Assistance. As the on attest that I have examined agency recommend the purpose of which is to violent to a determination of eligibility for the ct of 1998 and/or the American Recovery on are provided below.	ne signatory cords pertain verify person e provision o	I, a duly ning to the aboal information of services und	ove of der
	Results of Documentation Examination	1		
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	
purposes of verifying information	s the provision of this information shall be ation pertaining to the eligibility determina 29) of the Workforce Investment Act of 19	tion for the p	,	uth
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:				