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| **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:   AmeriCorps **State and National**   AmeriCorps **VISTA**   AmeriCorps **NCCC/FEMA** | **Please Check One:**   Regular Full Time (1700 Hours of) Service.   Half-time, Reduced Half-time, or Quarter Time.  Member is serving in:   Full Time Capacity  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**      **No**  | Will the member be required to complete service hours during the weekend? (\*Verification of weekend service hours will be needed)  Yes      No   Other\* (occasionally)  | | |
| A**MERICORPS** **PROGRAM DIRECTOR CERTIFICATION** | | | |
| |  | | --- | | ***I certify that the Member listed above is eligible to receive child care benefits, and I certify and affirm the following****:*   * 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 AmeriCorps Program Director Signature             Today’s Date (please print) | | | | |