Estes Valley Investment in Childhood Success

CHILD CARE SCHOLARSHIP FUND

(Please complete using black or blue ink.)

Child's Name: ____________________________ Birth Date: ______________________
Child's Name: ____________________________ Birth Date: ______________________
Child's Name: ____________________________ Birth Date: ______________________

Family structure: Single Parent ☐
Two Parents ☐
Guardian (relative) ☐
Other (describe) ☐ ____

Parent/Guardian Name 1: __________________________ Home Phone: _____________________
Address: __________________________ Work Phone: _____________________
__________________________ Cell Phone: _____________________
__________________________ Email: _____________________
Age: ___________

Employer or Educational Program: ____
____

Parent/Guardian Name 2: __________________________ Home Phone: _____________________
Address: __________________________ Cell Phone: _____________________
__________________________ Email: _____________________
__________________________ Age: ___________

Employer or Educational Program: ____
____

Names and relationship of all those in the household (please include all adults and children and the ages of other children):

__________________________ __________________________ __________________________
__________________________ __________________________ __________________________

Language(s) spoken in the household: ____

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Reason Child Requires Care:

- Parent(s) working ☐
- Parents(s) in school ☐
- Child has a special need ☐
- Other (describe) ☐ ____

____

Days/Hours Care Needed:

Child:_______________ Days/Hours: ____

Child:_______________ Days/Hours: ____

Provider you have chosen for care:

Name: ____________________________________

Address: ____________________________________

____

Phone #: ______________________

Assistance programs for which you qualify/are receiving funding (please check all that apply and attach copies of cards or verification):

	Qualify	Receiving	
Food stamps	☐	☐	
Free Lunch	☐	☐	
Reduced Lunch	☐	☐	
Child Support	☐	☐	
CCAP	☐	☐	
CHP+	☐	☐	
TANF	☐	☐	
Salud sliding scale	☐	☐	
Social Security	☐	☐	
Medicaid	☐	☐	
Scholarship	☐	☐	describe______________________________________
Other	☐	☐	describe______________________________________

Length of time you anticipate needing assistance: ___________________________________

Steps you are taking to help you lessen your need for assistance:

____

____

____

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Parent 1/Employer Name: ________________________ Phone #: ____________________
Hourly Wage: ____________________
Average Hours/Month: ____________________
Average Gross Monthly Wages: ____________________
How often are you paid: Monthly ☐
Weekly ☐
Twice a Month ☐

Parent 2/Employer Name: ________________________ Phone #: ____________________
Hourly Wage: ____________________
Average Hours/Month: ____________________
Average Gross Monthly Wages: ____________________
How often are you paid: Monthly ☐
Weekly ☐
Twice a Month ☐

Other Sources of Household Income:

Grants/Scholarships	☐	$ _________ per month
Child Support	☐	$ _________ per month
TANF	☐	$ _________ per month
Social Security	☐	$ _________ per month
Unemployment	☐	$ _________ per month
Family Support	☐	$ _________ per month
Other (describe)	☐	$ _________ per month

Total Monthly Household Income: $ _________ per month
Please attach copies of recent payroll stubs, verifying income.

Special financial circumstances you would like considered:
____
____

Education: High School diploma or GED? Yes ☐ No ☐
Other education: ____
Currently enrolled in an educational program? Yes ☐ No ☐
If yes, describe ____

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I certify by my signature below that the above information is true and complete. I understand that I have an obligation to report any changes within one month of the change (change in income, family size, employment status, etc.) to the Estes Valley Investment in Childhood Success Coordinator. I also understand that assistance will be terminated if I fail to pay the parent portion determined by EVICS. I give EVICS permission to verify information listed on this application.

_______________________________________ _______________________

Applicant's Signature Date

Authorization to Supply Information

I hereby authorize EVICS to supply information obtained from me to any child care provider I may choose to use, any employer for whom I work, or any school I may be attending.

Authorization to release Information

I authorize any child care provider I may choose to use, any employer for whom I work, any school I may be attending or any program for which I qualify for funding to supply information to EVICS concerning my application for subsidized child care through the EVICS child care scholarship fund. I release the person(s), agencies or institutions from any and all liability for supplying such information.

_______________________________________ _______________________

Applicant's Signature Date

Please return completed, signed application to: EVICS, PO Box 3373 Estes Park, CO 80517
or drop off at the EVICS Office, 600 S. St. Vrain Ave., # 200, Aspenwood Professional Bldg.
For questions or assistance please call 586-3055
You will be notified for a screening interview.

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EVICS Use Only

Family #: __________
Residency/Work verification: ______________
Provider eligibility: _______________________
Income verification: ______________________

Assistance with application(s) to other funding sources for which qualified? Yes ☐ No ☐
If yes, list____

Fund Assistance Granted? Yes ☐ No ☐

If No, Why? ____
____

Amount Granted: $ _________ per month
$ _________ catch-up of past due fees owed

Parent Fee: $ _________ per month

Duration of grant: Start date: _________________
End date: _________________

Number of times family has applied: ________________

Total amount granted past and current: $_______________

Comments:

January 2012