The Cabrini Fund
Catholic Charities Child Care Scholarships

I/We declare that the information included on this form and attachment, is true, correct and complete to the best of my knowledge. We authorize the Diocese to obtain any information necessary to verify the information included in or attached to this application.

Parent/Guardian Signature: _____

Print Name _____

Date: _____

Parent/Guardian Signature: _____

Print Name _____

Date: _____

Your application will only be considered if:

- All requested information is provided
- All required attachments are included

Please Note: Original documents will not be returned. This application, and all attachments, are handled in a confidential manner and securely stored.

Mail, deliver, or fax the completed, signed application, and all required attachments to:

The Cabrini Fund - Diocese of Providence
Catholic Social Service of RI
One Cathedral Sq.
Providence, RI 02903-4029

Fax: 401-453-6135

For further information, or to schedule an appointment for assistance with this application, contact the Diocese of Providence, Catholic Social Service of RI at 421-7833 x 223

For Office Use Only

Authorization # _____

Approved: _____
Date

Denied: _____
Date

Phone: 401-421-7833
Fax 401-453-6135
Email - fgarcia@dioceseofprovidence.org

Rev. 10-3-16

Family Information

Complete for all adults <u>living with the child</u>

Relationship to Child

Circle one: Mother Stepmother Grandmother Other

Name: _____
First   MI   Last

Date of Birth: Month____Day____Year_____

Phone #: Day_____

Night_____

Email: _____

Relationship to Child

Circle one: Father Stepfather Grandfather Other

Name: _____
First   MI   Last

Date of Birth: Month____Day____Year_____

Phone #: Day_____

Night_____

Email: _____

Address: _____
Street   Apt. #/Floor

_____
City/Town   State   Zip

Total # of hours worked each week _____

Name of Employer_____

Work Phone #_____

Job Title/Rank_____

If self employed_____
Type of work/business

Total # of hours worked each week _____

Name of Employer_____

Work Phone #_____

Job Title/Rank_____

If self employed_____
Type of work/business

If not employed check all that apply:

Full time family care: _____
Student: _____
Disabled: _____
Retired: _____
Other: _____

Full time family care: _____
Student: _____
Disabled: _____
Retired: _____
Other: _____

Chosen Daycare or Before/After School Provider: _____

Name of Child for whom scholarship is requested: _____
(one child per household)

Who Lives in this Household?
List all children and adults (except adults previously listed)

Name:		Date of Birth	Gender	Working?
First	Last	Month Day Year	M/F	Y/N
First	Last	Month Day Year	M/F	Y/N
First	Last	Month Day Year	M/F	Y/N
First	Last	Month Day Year	M/F	Y/N
First	Last	Month Day Year	M/F	Y/N

(Attach additional pages if necessary)

Family Income
This is the gross income (before any deductions) for all household members.

Source	Amount	How often are you paid?			
(Check all in household)		(Check one for each type of income)			
_____Employment	$_____	Weekly___	Bi Weekly___	Monthly ____	Yearly ____
_____Employment	$_____	Weekly___	Bi Weekly___	Monthly ____	Yearly ____
_____Unemployment	$_____	Weekly___	Bi Weekly___	Monthly ____	Yearly ____
_____DHS/State	$_____	Weekly___	Bi Weekly___	Monthly ____	Yearly ____
_____Child Support	$_____	Weekly___	Bi Weekly___	Monthly ____	Yearly ____
_____SSI	$_____	Weekly___	Bi Weekly___	Monthly ____	Yearly ____
_____SSD	$_____	Weekly___	Bi Weekly___	Monthly ____	Yearly ____
_____Pension	$_____	Weekly___	Bi Weekly___	Monthly ____	Yearly ____
_____Disability	$_____	Weekly___	Bi Weekly___	Monthly ____	Yearly ____
_____Other	$_____	Weekly___	Bi Weekly___	Monthly ____	Yearly ____

(Please specify) _____

In addition to pay stubs, please attach documentation verifying other forms of income

Child Support Paid Out

Does any adult in this household <u>pay</u> child support for children not living in this household?

Yes_____   No_____

If yes, how much was paid in the past year? $_____

Child Care Assistance from Department of Human Services (DHS)

Do you receive assistance from DHS in paying for child care?   Yes_____   No_____

If yes, what is your DHS <u>co-pay amount?</u> $_____

Families receiving assistance from DHS may be eligible for a Cabrini Scholarship

If denied by DHS we will need a copy of denial letter.

Please add any information you would like to share with the scholarship committee:

_____

_____

_____

_____

For reporting purposes ONLY – (this information is not necessary to determine eligibility)

What is your religious affiliation? _____Catholic _____
                                                                                Name of Parish   City/Town

____Baptist ____Lutheran ____Jewish ____Muslim ____None ____Other_____

Please Note: You will only receive verbal notification of the results of this application if there is a current open space available. If the program has a waitlist you will be verbally contacted once a spot is open and the committee has reviewed your application for eligibility.