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CHILD CARE SCHOLARSHIP APPLICATION Academic Year 2010 - 2011

PROVIDER VERIFICATION FORM

Family Information (for additional children, please see the back of this form)

1. Parent name: _____
2. Child's name: _____
3. Child's date of birth: _____ / _____ / _____
4. Child's age: _____
5. Date child started/will start attendance: _____ / _____ / _____
6. Date child is scheduled to end attendance: _____ / _____ / _____ OR no end date (circle)

Provider Information

1. Provider name: _____
2. Mailing address: _____
3. City: _____ State: _____ Zip: _____
4. Contact person: _____ Phone number: _____

Provider Cost Information (for additional children, please see the back of this form)

For the months the child will be enrolled at your facility, please indicate the total child care cost per month.

2010	Sept	Oct	Nov	Dec	2011	Jan	Feb	Mar	Apr	May
	\$ _____	\$ _____	\$ _____	\$ _____		\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

If the parent will be receiving other financial assistance to pay for child care, please indicate here:

Source: _____ Amount: \$ _____ Start: _____ End: _____

Provider Licensure Information

Please provide the following information with this form

- A copy of your state child care license
- A copy of your IRS Form W9, "Request for Taxpayer Identification Number and Certification." If you do not have a W9 Form, please request one from 10,000 Degrees' Scholarships Department.

Provider Signature: _____ Date: _____

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Additional Children

Child 2: Family Information

- 1. Child's name: _____
- 2. Child's date of birth: _____ / _____ / _____
- 3. Child's age: _____
- 4. Date child started/will start attendance: _____ / _____ / _____
- 5. Date child is scheduled to end attendance: _____ / _____ / _____ OR no end date (circle)

Child 2: Provider Cost Information

For the months the child will be enrolled at your facility, please indicate the total child care cost per month.

2010	Sept	Oct	Nov	Dec	2011	Jan	Feb	Mar	Apr	May
	\$_____	\$_____	\$_____	\$_____		\$_____	\$_____	\$_____	\$_____	\$_____

If the parent will be receiving other financial assistance to pay for child care, please indicate here:

Source: _____ Amount: \$_____ Start: _____ End: _____

Child 3: Family Information

- 1. Child's name: _____
- 2. Child's date of birth: _____ / _____ / _____
- 3. Child's age: _____
- 4. Date child started/will start attendance: _____ / _____ / _____
- 5. Date child is scheduled to end attendance: _____ / _____ / _____ OR no end date (circle)

Child 3: Provider Cost Information

For the months the child will be enrolled at your facility, please indicate the total child care cost per month.

2010	Sept	Oct	Nov	Dec	2011	Jan	Feb	Mar	Apr	May
	\$_____	\$_____	\$_____	\$_____		\$_____	\$_____	\$_____	\$_____	\$_____

If the parent will be receiving other financial assistance to pay for child care, please indicate here:

Source: _____ Amount: \$_____ Start: _____ End: _____