Academic year 2021 – 2022

CHILDCARE SCHOLARSHIP
PROVIDER VERIFICATION FORM

Family Information (Please complete one form per child):

1. Parent name: ______________________________
2. Child's name: ______________________________
3. Child's date of birth: ________ / ______ / ______ 4. Child's age: ______________________
5. Date child started/will start attendance: ____________ / ______ / ____________

Provider Information:

1. Provider name (**As shown on W-9**): ______________________________
2. Mailing address: ______________________________
3. City: ______________________________ State: ______________ Zip: ________________
4.Contact person: ______________________________
5. Phone number: ______________________________ E-mail Address:______________________________

Provider Cost Information:

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

(FALL SEMESTER)				(SPRING SEMESTER)				
Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May
$_______	$_______	$________	$________	$_______	$_______	$_______	$_______	$_______

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

Source: ___________________________ Amount: $______________________

Provider Licensure Information:

Please provide the following information with this form

- A copy of your child care provider's state license
- A copy of your child care provider's IRS Form W-9, "Request for Taxpayer Identification Number and Certification."

Provider Signature: ____ Date: _________

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