Academic Year 2024 – 2025

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:

Please indicate the total childcare cost for each month that child will be enrolled at your facility

FALL SEMESTER:

September $_____October $_____November $_____December $_____

SPRING SEMESTER:

January $_____February $_____March $_____April $_____May $_____

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

Source: _____ Amount: $_____

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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