

# BEST BEGINNINGS CHILD CARE SCHOLARSHIP

## ATTACHMENT E

### SCHOOL / TRAINING VERIFICATION

#### DIRECTIONS for Applicant / Student

1. **Complete Section 1**
  - Applicant / Student – Permission to Release Information
2. **Have a School Official from the school you are attending complete sections 2 and 3**
  - School Information and School Official Certification
3. **Return completed form via fax to your Child Care Resource and Referral Agency**

Region 1	The Nurturing Center	Fax: (406) 756-1410
Region 2	Child Care Resources	Fax: (406) 549-1189
Region 3	Butte 4 C's	Fax: (406) 723-6982
Region 4	Child Care Connections	Fax: (406) 587-1682
Region 5	Family Connections MT Great Falls	Fax: (406) 453-8976
Region 6	Family Connections MT Havre	Fax: (406) 265-1312
Region 7	HRDC District 7	Fax: (406) 869-2585

#### 1. APPLICANT / STUDENT - PERMISSION TO RELEASE INFORMATION

I, \_\_\_\_\_, grant permission to \_\_\_\_\_ for the release the information requested on this form to the Child Care Resource and Referral Agency, listed above, in order to determine my family's eligibility for the Best Beginnings Child Care Scholarship.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### DIRECTIONS for School Official

The individual listed above has applied for a Best Beginnings Child Care Scholarship. The Best Beginnings Child Care Scholarship helps qualifying Montana families pay for their child care costs, while participating in qualifying activities, such as work and school. The student applicant's signature above authorizes the release of the information requested on this form. By completing this form you are providing information about the identified individual that will be used to determine their eligibility for child care assistance. Thank you for your cooperation.

CCR&R OFFICE USE ONLY	CS _____ CE _____		HoH Name		Date Received	
	Begin Date	End Date	Reason	Determination Date	Determined By	

## 2. APPLICANT / STUDENT SCHEDULE

MONTHLY SCHOOL SCHEDULE	- Please indicate the time the student's first class starts and the time the student's last class ends on any given day. - Please provide an official copy of the students class schedule						
	This schedule is good for the following semester: (indicate year) <input type="checkbox"/> Fall _____ <input type="checkbox"/> Spring _____ <input type="checkbox"/> Summer _____						
	The semester that this schedule covers runs from: _____ to: _____						
	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm
	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day
	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm	am/pm to am/pm
	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day	Hrs per day
	<input type="checkbox"/> This schedule remains the same for the entire month				<input type="checkbox"/> This schedule varies from week to week		
If school schedule varies, please explain:							

## 3. STUDENT / APPLICANTS' - SCHOOL INFORMATION

Student Name:	
School Name:	School Address:
Course of Study / Training Program	
Is this a Part Time or Full Time Student? <input type="checkbox"/> Part Time ( _____ hrs per week) <input type="checkbox"/> Full Time ( _____ hrs per week)	How many credits is this student taking per semester? _____ credits per semester
Does this individual currently hold a bachelor's degree? If Yes, what is the degree in? _____ When was it earned? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

## 4. SCHOOL OFFICIAL CERTIFICATION (to be signed by a school official)

<b>PLEASE READ AND SIGN:</b>		
I certify that the above information is true and correct to the best of my knowledge and that I have the authority to make such verification on behalf of this company.		
School Official Name (please print)	Title	Phone Number
School Official Signature	Date	