



# COMMUNITY BEFORE & AFTER SCHOOL CHILD CARE PROGRAM (CAP)



## SCHOLARSHIP APPLICATION COVER SHEET

*Please complete and return entire application packet*

Parent's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Child's Name: \_\_\_\_\_ Child's Age: \_\_\_\_\_  
 Child's School: \_\_\_\_\_ Child's Grade in School: \_\_\_\_\_  
 Scholarship Needed for: \_\_\_\_\_ CAP Site Needed: \_\_\_\_\_  
*(i.e., School Year or Summer)*

Scholarship money is available for working parents/guardians that demonstrate a financial need. Scholarships will be provided based on family need, household income, and in some cases principal and/or counselor recommendation.

Applicants need to complete **all** pages of the Scholarship Application Packet. Applicants must address all questions on the application AND provide the following information *before* CAP will review your application. Please check each box below as you gather the required information. **Please allow two (2) weeks for processing.**

- Provide proof of income for all employed members of your household (*most recent paystub*).
- Provide a receipt\* that you have applied for Employment/Education Related Day Care (ERDC) with the State of Oregon Department of Human Services located at 118 Second Avenue SE, Albany, phone 541-967-2060. Once a decision has been made by ERDC, a notice of eligibility will be sent to your mailing address within 2-3 business days. This notice or "receipt" is required and must accompany your application before financial assistance will be reviewed.  
\*It is a Federal requirement that a notice of eligibility will be sent to your mailing address within 2-3 business days after ERDC application. This eligibility notice is your "receipt." If you are unable to locate your notice of eligibility receipt, a new notice will be printed upon request.
- Provide proof of medical expenses, *if applicable*.
- Provide a brief statement containing your work hours and the hours your child(ren) will be utilizing the CAP program.

Once a decision has been made, the applicant will receive notice as to whether or not scholarship money is available. Scholarships will begin on the 1<sup>st</sup> day of the month after the scholarship committee awards the scholarship. Scholarships will not be retroactive. If you receive a partial-year scholarship and you wish to reapply for continued scholarship funding, it will be your responsibility to submit a new and updated application. Please return this cover sheet along with your completed application form to:

**COMMUNITY BEFORE & AFTER SCHOOL CHILD CARE PROGRAM (CAP)**  
 250 Broadalbin Street, Suite 255—PO BOX 1717, Albany, OR 97321  
 Phone: 541-967-9322—Fax: 541-967-8368—Website: [www.cap.peak.org](http://www.cap.peak.org)

### **FOR OFFICE USE ONLY**

| Items Needed               | Date Received | Items Needed            | Date Received |
|----------------------------|---------------|-------------------------|---------------|
| Proof of income received   |               | Statement of work hours |               |
| Receipt from ERDC          |               | Program hours needed    |               |
| Proof of any medical costs |               | Other, if applicable    |               |

Date Approved: \_\_\_\_\_ Scholarship Amount: \_\_\_\_\_ Beginning Date: \_\_\_\_\_  
 Date Denied: \_\_\_\_\_ Reason for Denial: \_\_\_\_\_

*"The USDA and the State of Oregon are equal opportunity providers."*



**COMMUNITY BEFORE & AFTER SCHOOL  
CHILD CARE PROGRAM (CAP)**



**SCHOLARSHIP APPLICATION FORM**

Parent/Guardian's Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Mailing Address (if different than above): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Parent/Guardian's Employer Name & Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Phone: \_\_\_\_\_ Rate of pay & How often: \_\_\_\_\_

**Please list all adult people living with you in your household (not including yourself).**

*(Write N/A if adult is not employed. Add additional sheets if necessary.)*

Name: \_\_\_\_\_ Employed with: \_\_\_\_\_ Amount: \_\_\_\_\_

Name: \_\_\_\_\_ Employed with: \_\_\_\_\_ Amount: \_\_\_\_\_

Name: \_\_\_\_\_ Employed with: \_\_\_\_\_ Amount: \_\_\_\_\_

Name: \_\_\_\_\_ Employed with: \_\_\_\_\_ Amount: \_\_\_\_\_

Name: \_\_\_\_\_ Employed with: \_\_\_\_\_ Amount: \_\_\_\_\_

**Please list any additional income sources for yourself or anyone else in your household, such as, Alimony, Child Support, Social Security Benefits, Food Stamps, TANF grants, SSI, etc.**

*(Write N/A if none, add additional sheets if necessary.)*

Name: \_\_\_\_\_ Funding Received: \_\_\_\_\_ Amount: \_\_\_\_\_

Name: \_\_\_\_\_ Funding Received: \_\_\_\_\_ Amount: \_\_\_\_\_

Name: \_\_\_\_\_ Funding Received: \_\_\_\_\_ Amount: \_\_\_\_\_

Name: \_\_\_\_\_ Funding Received: \_\_\_\_\_ Amount: \_\_\_\_\_

**Please list any additional financial assistance for yourself or anyone else in your household, such as housing assistance (HUD) or utility/energy assistance.**

*(Write N/A if none, add additional sheets if necessary.)*

Name: \_\_\_\_\_ Funding Received: \_\_\_\_\_ Amount: \_\_\_\_\_

Name: \_\_\_\_\_ Funding Received: \_\_\_\_\_ Amount: \_\_\_\_\_

Name: \_\_\_\_\_ Funding Received: \_\_\_\_\_ Amount: \_\_\_\_\_

**Please list and attach proof of your monthly medical costs for each family member.**

*(Write N/A if none, add additional sheets if necessary.)*

Name: \_\_\_\_\_ Amount: \_\_\_\_\_

Name: \_\_\_\_\_ Amount: \_\_\_\_\_

Name: \_\_\_\_\_ Amount: \_\_\_\_\_

Name: \_\_\_\_\_ Amount: \_\_\_\_\_

**SCHOLARSHIP APPLICATION FORM CONTINUED**

**Please list the following household expenses.**

Housing payment.....\$ \_\_\_\_\_

Utilities:

    Electric.....\$ \_\_\_\_\_

    Water.....\$ \_\_\_\_\_

    Phone.....\$ \_\_\_\_\_

    Gas.....\$ \_\_\_\_\_

    Cable.....\$ \_\_\_\_\_

Transportation Costs:

    Car Payment.....\$ \_\_\_\_\_

    Car Insurance.....\$ \_\_\_\_\_

    Monthly Fuel.....\$ \_\_\_\_\_

Other Expenses: *(please list)*

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

Have you or anyone else in your household applied for childcare assistance with any other agency, such as the Department of Human Services (formerly AFS), etc.? **(circle one)**      Yes      No

Please provide a brief statement containing your work hours and the hours your child(ren) will need to be at the CAP program. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there any other information you feel CAP should know regarding your particular circumstances?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Certification Statement:** I certify that to the best of my knowledge and belief that the above information is correct and complete. If I have made any misrepresentations on this application, I will be asked to return any scholarship money received. Scholarship applications are reviewed on a monthly basis, and ARE NOT retroactive, (i.e., if your application is reviewed in October, and approved, your scholarship will begin in November and you will be responsible for September and October).

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse/Partner Signature: \_\_\_\_\_ Date: \_\_\_\_\_