

+ ☐ Original

SOUTH CENTRAL WDC WIA APPLICATION FOR CHILDCARE

☐ Modification

(attach a completed W-9 form with childcare application)

SUBCODE

Training Component: _____ Total Contract Period: _____ to _____.

Date: _____ Name: _____ SSN: _____ - _____ - _____

Address: _____

Name & Location of Training Site: _____

Daily Schedule of Training Hours: _____

(*payment will include 1hr. of travel time added to daily scheduled hours for drop off and pick up allowance)

If you are living with a spouse, are they currently employed? ☐ NA ☐ Yes ☐ No

(_____ **cannot** provide childcare assistance if spouse is unemployed and living in the home)

Is childcare to be provided by a licensed provider?

☐ Yes ☐ No

If no, state rationale why licensed facility will **not** be used: _____

IF NOT LICENSED:

Is childcare to be provided in child's home?

☐ Yes ☐ No

Provider's Name: _____ Phone# _____ SSN# _____ - _____ - _____

Address: _____

What is their relationship to you? _____

IF LICENSED CHILDCARE CENTER:

Name: _____ Phone: _____ TAX# _____

Address: _____

Cost of childcare. List rates for hourly & daily for each child. Payment will follow time sheet completion and does **NOT** include any **non-training days**.

How many hours constitute a daily rate? _____

(The hourly rate paid should never be more than the maximum daily rate allowed)

I am requesting Childcare payments for the following children at the listed rates:

<u>Name of Child</u>	<u>Age</u>	<u>Hourly rate</u>	<u>Daily rate</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

"I certify the answers I have given are true to the best of my knowledge. I understand any false or misleading information may incur REPAYMENT liability. I understand payment for childcare is paid only for scheduled hours of WIA training as documented by timesheets and that childcare can be terminated due to non attendance or failure to deliver necessary documents."

Participant Signature

Date

Childcare Provider Signature

Date

If modification, complete: Mod. ☐ I ☐ II ☐ III. Start date of **original** _____ Total (\$) obligated:

Orig. \$ _____, Mod I \$ _____, Mod II \$ _____ Mod III \$ _____. YTD Grand Total \$ _____.

Obligated Amount: (Dates) Start: _____ End _____. Rate of \$ _____ per day multiplied by _____ total training days = \$ _____.

☐ Approved ☐ Disapproved / Reason: _____

Supervisor Signature

Date

Case Manager Signature

Date