BEST BEGINNINGS CHILD CARE SCHOLARSHIP
ATTACHMENT E
SCHOOL / TRAINING VERIFICATION

DIRECTIONS FOR APPLICANT / EMPLOYEE

1. Complete Section 1
   - Applicant / Employee – Permission to Release Information

2. Have your current employer 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 / EMPLOYEE – PERMISSION TO RELEASE INFORMATION

I, _______________________________, grant permission to ___________________________________ for the release of the information requested on this form to the Child Care Resource and Referral Agency, listed above, 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.

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<th>HoH Name</th>
<th>Date Received</th>
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<td>End Date</td>
<td>Reason</td>
<td>Determination Date</td>
<td>Determined By</td>
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ATTACHMENT D: Work Verification: DPHHS-HCS/CC-159 (rev 08/15)
2. **APPLICANT / STUDENT 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 student’s class schedule

This schedule is good for the following semester: (indicate year) ☐ Fall ☐ Spring ☐ Summer ☐

The semester that this schedule covers runs from: ________________ to: ________________

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<th>TUESDAY</th>
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☐ This schedule remains the same for the entire month  ☐ This schedule varies from week to week

If school schedule varies, please explain:

3. **STUDENT / APPLICANTS – SCHOOL INFORMATION**

Student Name: __________________________

School Name: ___________________________  School Address: ___________________________

Enrollment Date: ________________________

Course of Study / Training Program: ___________________________

Anticipated graduation / completion date: ________________________

Expected Degree / Certificate: __________________________

Is this a Part Time or Full Time Student?

☐ Part Time (________ hrs per week)  ☐ Full Time (________ hrs per week)

How many credits is this student taking per semester? ________ credits per semester

Is this student in good academic standing?

If No, please explain: (Is this individual on probation?)

☐ Yes, good  ☐ No

Does this individual currently hold a bachelor’s degree?

If Yes, what is the degree in? ___________________________

When was it earned? ___________________________

☐ Yes  ☐ No

4. **EMPLOYER CERTIFICATION (to be signed by employer)**

**PLEASE READ AND SIGN:**

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