I/We declare that the information included on this form and attachment, is true, correct and complete to the best of my knowledge. We authorize the Diocese to obtain any information necessary to verify the information included in or attached to this application.

Parent/Guardian Signature: ________________________________
Parent/Guardian Signature: ________________________________

Print Name     ___________________________________________________
Print Name     ___________________________________________________

Date: _____________________    Date: ________________________________

Your application will only be considered if:
- All requested information is provided
- All required attachments are included

Please Note: Original documents will not be returned. This application, and all attachments, are handled in a confidential manner and securely stored.

Mail, deliver, or fax the completed, signed application, and all required attachments to:

The Cabrini Fund - Diocese of Providence
Catholic Social Service of RI
One Cathedral Sq.
Providence, RI 02903-4029
Fax: 401-453-6135

For further information, or to schedule an appointment for assistance with this application, contact the Diocese of Providence, Catholic Social Service of RI at 421-7833 x 223

---

For Office Use Only

Approved: ___________________    Authorization # __________________
Date: ________________________

Denied: _______________________    ________________________________
Date: ________________________

Phone: 401-421-7833
Fax 401-453-6135
Email - fgarcia@dioceseofprovidence.org

Rev. 09-19-17

---
Family Information

Complete for all adults living with the child

Relationship to Child
Circle one: Mother  Stepmother  Grandmother  Other

Name: ____________________________________
          First    MI    Last

Date of Birth: Month_____Day_____Year______

Phone #: Day______________________________
          Night______________________________

Email: ________________________________

Address: ____________________________________________
          Street                                       Apt. #/Floor
          City/Town                                   State                      Zip

Total # of hours worked each week   ____________

Name of Employer___________________________

Work Phone #_______________________________

Job Title/Rank_______________________________

If self employed______________________________
          Type of work/business

If not employed check all that apply:

Full time family care: ____________
Student: _______________________
Disabled: ____________
Retired: ____________
Other: ____________

Full time family care: ____________
Student: _______________________
Disabled: ____________
Retired: ____________
Other: ____________

Chosen Daycare or Before/After School Provider: ________________________________

Name of Child for whom scholarship is requested: ________________________________

(one child per household)
**Who Lives in this Household?**
List all children and adults (except adults previously listed)

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Birth</th>
<th>Gender</th>
<th>Working?</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>Last</td>
<td>Month</td>
<td>Day</td>
</tr>
<tr>
<td>M/F</td>
<td></td>
<td></td>
<td>Y/N</td>
</tr>
</tbody>
</table>

(Attach additional pages if necessary)

**Family Income**
This is the gross income (before any deductions) for all household members.

### Source

(Check all in household)

### Amount

(Check one for each type of income)

### How often are you paid?

(Attach additional pages if necessary)

- **Employment**
  - $___________  Weekly___  Bi Weekly___  Monthly___  Yearly___

- **Unemployment**
  - $___________  Weekly___  Bi Weekly___  Monthly___  Yearly___

- **DHS/State**
  - $___________  Weekly___  Bi Weekly___  Monthly___  Yearly___

- **Child Support**
  - $___________  Weekly___  Bi Weekly___  Monthly___  Yearly___

- **SSI**
  - $___________  Weekly___  Bi Weekly___  Monthly___  Yearly___

- **SSD**
  - $___________  Weekly___  Bi Weekly___  Monthly___  Yearly___

- **Pension**
  - $___________  Weekly___  Bi Weekly___  Monthly___  Yearly___

- **Other**
  - $___________  Weekly___  Bi Weekly___  Monthly___  Yearly___

(Please specify) ____________________

In addition to pay stubs, please attach documentation verifying other forms of income
Child Support Paid Out
Does any adult in this household pay child support for children not living in this household?  
Yes_____  No_____  
If yes, how much was paid in the past year? $__________________

Child Care Assistance from Department of Human Services (DHS)
Do you receive assistance from DHS in paying for child care?  
Yes_____  No_____  
If yes, what is your DHS co-pay amount?  $__________________

Families receiving assistance from DHS may be eligible for a Cabrini Scholarship
If denied by DHS we will need a copy of denial letter.

Please add any information you would like to share with the scholarship committee:
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

For reporting purposes ONLY – (this information is not necessary to determine eligibility)
What is your religious affiliation?  _______Catholic  _______________________________
                                 Name of Parish  City/Town
                                 _______Baptist ___Lutheran ___Jewish ___Muslim ___None ___ Other __________

Please Note: You will only receive verbal notification of the results of this application if there is a current open space available. If the program has a waitlist you will be verbally contacted once a spot is open and the committee has reviewed your application for eligibility.