☐ Original **SOUTH CENTRAL WORKFORCE WIOA APPLICATION FOR CHILDCARE**

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

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:

Name of Child	Age	Hourly rate	Daily rate
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

"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 WIOA 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