**GROWING TOGETHER PRESCHOOL, INC.**

**SCHOLARSHIP APPLICATION**

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| CHILD'S NAME: | | DOB: |
| CHILD'S ADDRESS: | | |
| PARENT: | PARENT: | |
| ADDRESS:  PHONE: HOME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  CELL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  WORK: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ADDRESS:  PHONE: HOME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  CELL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  WORK: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| CHILD LIVES WITH: \_\_\_\_\_MOTHER \_\_\_\_\_FATHER \_\_\_\_\_BOTH \_\_\_\_\_FOSTER \_\_\_\_\_OTHER | | |
| FAMILY SIZE: \_\_\_\_\_ADULTS \_\_\_\_\_CHILDREN | | |
| CHILD'S DIAGNOSIS: | | |
| THERAPIES CHILD NEEDS/RECIEVES: | | |
| DO YOU OR ANYONE IN YOUR HOUSEHOLD RECEIVE ADDITIONAL FINANCIAL ASSISTANCE FROM ANY OF THE FOLLOWING?  UNEMPLOYMENT $\_\_\_\_\_\_\_\_\_\_ ALIMONY $\_\_\_\_\_\_\_\_\_\_ CHILD SUPPORT $\_\_\_\_\_\_\_\_\_\_  SOCIAL SECURITY $\_\_\_\_\_\_\_\_\_\_ OTHER $\_\_\_\_\_\_\_\_\_\_ | | |
| PLEASE EXPLAIN ANY SPECIAL FINANCIAL CIRCUMSTANCES AFFECTING THE FAMILY'S BUDGET AT THIS TIME: | | |
| PLEASE EXPLAIN HOW YOU FEEL A RELATIONSHIP WITH GROWING TOGETHER PRESCHOOL WOULD BENEFIT YOUR CHILD AND FAMILY: | | |
| ARE YOU ABLE TO CONTRIBUTE ANY FINANCES TO YOUR CHILD'S TUITION: \_\_\_\_\_Y \_\_\_\_\_N  IF SO, HOW MUCH? $\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| I HEREBY CERTIFY THAT ALL THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT. IN ADDITION, I HAVE ATTACHED DOCUMENTATION OF MY CHILD'S DIAGNOSIS, CHILD CARE ASSISTANCE FUNDING, HEAD START APPLICATION AND PROOF OF INCOME. I ALSO UNDERSTAND THAT ANY MISREPRESENTATION OF THE INFORMATION CONTAINED IN THIS DOCUMENT DOES CONSTITUTE FRAUD AND I WILL, THEREFORE, BE REQUIRED TO REPAY ALL SCHOLARSHIP FUNDS. I UNDERSTAND THAT MY CHILD MUST NOT MISS MORE THAN FIVE (5) UNEXCUSED DAYS EACH MONTH AND THAT THE SCHOLARSHIP FUNDS DO NOT COVER MISSED DAYS NOT COVERED BY THE CHILD CARE ASSISTANCE PROGRAM. | | |
| SIGNATURE OF PARENT/GUARDIAN: | | |
| SIGANTURE OF PARENT/GUARDIAN: | | |
| DATE: | | |