



**Remember to complete entire application & include:  
Copies of last (2) paystubs from each parent or guardian  
AND copy of last year's tax return.**

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

## 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: \_\_\_\_\_

### Relationship to Child

Circle one: Father Stepfather Grandfather Other

Name: \_\_\_\_\_  
First MI Last

Date of Birth: Month \_\_\_\_ Day \_\_\_\_ Year \_\_\_\_

Phone #: Day \_\_\_\_\_

Night \_\_\_\_\_

Email: \_\_\_\_\_

Total # of hours worked each week \_\_\_\_\_

Name of Employer \_\_\_\_\_

Work Phone # \_\_\_\_\_

Job Title/Rank \_\_\_\_\_

If self employed \_\_\_\_\_

Type of work/business

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)

| Name:          |               | Date of Birth           | Gender       | Working?     |
|----------------|---------------|-------------------------|--------------|--------------|
| _____<br>First | _____<br>Last | _____<br>Month Day Year | _____<br>M/F | _____<br>Y/N |
| _____<br>First | _____<br>Last | _____<br>Month Day Year | _____<br>M/F | _____<br>Y/N |
| _____<br>First | _____<br>Last | _____<br>Month Day Year | _____<br>M/F | _____<br>Y/N |
| _____<br>First | _____<br>Last | _____<br>Month Day Year | _____<br>M/F | _____<br>Y/N |
| _____<br>First | _____<br>Last | _____<br>Month Day Year | _____<br>M/F | _____<br>Y/N |

(Attach additional pages if necessary)

### Family Income

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

| <u>Source</u>            | <u>Amount</u> | <u>How often are you paid?</u>      |                |              |             |
|--------------------------|---------------|-------------------------------------|----------------|--------------|-------------|
| (Check all in household) |               | (Check one for each type of income) |                |              |             |
| ____ Employment          | \$ _____      | Weekly ____                         | Bi Weekly ____ | Monthly ____ | Yearly ____ |
| ____ 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 ____ |
| ____ Disability          | \$ _____      | 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:

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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.