

Pathways To Success

"Pathways To Success:

The support you need to accomplish your goals"

Application for Child Care OR Transportation Assistance

Eligibility Requirements:

1) Qualifying students must meet at least **one** of the following criteria:

- a) Single Parents
- b) Single Pregnant Women
- c) Displaced Homemakers
- d) Students with Disabilities
- e) Students Preparing for Non-Traditional Fields
- f) Students with Limited English Proficiency
- g) Economically Disadvantaged Students

AND

- 2) Be a current Grayson College student enrolled in an Associate of Applied Science (AAS) or Certificate program
- 3) Have a current cumulative GPA of at least a 2.0
- 4) Be eligible to receive Pell Grant

Required Documents:

- If applying for Transportation OR Childcare Assistance you **must submit** the following
 - Completed Pathways to Success **Application**
 - Transportation – Pages 2 & 3 ONLY
 - Childcare – Pages 2 - 5
 - Proof of **Pell Award**
 - Copy of your class **schedule**
 - Copy of your **college transcript**
- If applying for Childcare Assistance you **must also submit** the following:
 - Copy of **birth certificate** for each child you are requesting child care assistance
 - Completed **Childcare Provider Verification form**
 - The Childcare Provider **must be** one of the following:
 - **Licensed** child care center (Texas or Oklahoma)
 - **Registered** child care home (Texas)
 - **Licensed** child care home (Oklahoma)

Helpful websites:

Texas: http://www.dfps.state.tx.us/Child_Care/Search_Texas_Child_Care/ppFacilitySearchDayCare.asp

Oklahoma: <http://childcarefind.okdhs.org/childcarefind/>

Priority Deadlines to apply for funding:

<u>Semester</u>	<u>Priority Deadline</u>
Fall	August 1
Spring	December 1
Summer	May 1

Applications **will be accepted** after priority deadline; however, priority consideration is given to applications received before the deadline.

Please return completed application and all required documentation to:

Amanda Ulliman
Coordinator of Special Services
Grayson College, Main Campus
6101 Grayson Drive
Denison, TX 75020
ullimana@grayson.edu

Applications will not be processed until **all** required documentation is received.

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Your Information

Fill in each blank. Please print legibly.

Assistance Requested (Select ONE) <input type="checkbox"/> Child care assistance <input type="checkbox"/> Transportation assistance		Semester(s) Requesting Assistance: <input type="checkbox"/> Fall <input type="checkbox"/> Spring <input type="checkbox"/> Summer		Date Application Submitted:	
Applicant Name: (First) (Last)		Date of Birth:	Student ID Number:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address:			City/State:		Zip:
Physical Address: (if different)			City/State:		Zip:
Home Phone:		Cell Phone:		Work Phone:	
Major:	Current Overall GPA:	Email Address: (Communication will be sent by email.)			
Educational Goals: Why are you attending college? What are your goals?					
Have you completed the FAFSA application? <input type="checkbox"/> Yes <input type="checkbox"/> No Date completed: _____ EFC: _____					
Are you a single parent (separated, divorced, widowed, never married) who has custody or joint custody of minor children? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Are you a single, pregnant woman? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Are you a displaced homemaker? Have you primarily devoted yourself to making a home and then were left alone because of separation, divorce, death, or an absent spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is English your native language? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you require accommodations related to a physical, mental or learning disability? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Are you seeking training for employment in a position usually occupied by the opposite sex, a non-traditional job? (Ex: a male nurse, female welder) <input type="checkbox"/> Yes <input type="checkbox"/> No					

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Spouse or Significant Other's Information (*Only if living within the same household*)

Name: (First)	(Last)	Date of Birth:	Cell Phone:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
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Information Regarding Each Additional Household Member Under Age 18

1. Child's Name:		Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to you:
Does the child need care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of care needed: <input type="checkbox"/> Full-Day <input type="checkbox"/> After school <input type="checkbox"/> Part-Day <input type="checkbox"/> No Care Needed		Days of Week Care Needed: <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Fri	
2. Child's Name:		Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to you:
Does the child need care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of care needed: <input type="checkbox"/> Full-Day <input type="checkbox"/> After school <input type="checkbox"/> Part-Day <input type="checkbox"/> No Care Needed		Days of Week Care Needed: <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Fri	
3. Child's Name:		Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to you:
Does the child need care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of care needed: <input type="checkbox"/> Full-Day <input type="checkbox"/> After school <input type="checkbox"/> Part-Day <input type="checkbox"/> No Care Needed		Days of Week Care Needed: <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Fri	

Do You Receive Any of the Following?

WIA or Assistance from Workforce Texoma <input type="checkbox"/> Yes <input type="checkbox"/> No	PELL Grant <input type="checkbox"/> Yes <input type="checkbox"/> No	Transportation Assistance from Workforce Texoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Child care assistance through a local Workforce Center? <input type="checkbox"/> I have applied for CCMS (Child Care Management Services). <input type="checkbox"/> I am on the CCMS waiting list/not currently funded. <input type="checkbox"/> I have been approved and will begin CCMS funding on _____. <input type="checkbox"/> I am currently receiving CCMS.
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I certify that the information I have given on this form is true and correct to the best of my knowledge.

Applicant's Signature: _____	Date: _____
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For Child Care Assistance Applicants Only

Privacy release statement
Authorization to release information

Name of child care provider: _____

I authorize the above-referenced child care provider to release information concerning child care services for my child(ren) and to release any information concerning other funding sources that I receive. I give permission for the Coordinator of Special Services to release information to my child care provider. Information is limited to: billing and payment information for child care services, class schedule, child care schedule, and child(ren) attendance. In addition, I understand that if I am eligible for funding through Workforce Texoma - Child Care Management Services, I must report this to the Coordinator of Special Services prior to my first payment.

Student Signature: _____ Date: _____

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Grayson College
Pathways To Success
Child Care Provider Verification Form

GC Student/Parent: _____
First Last

Child(ren) in Daycare:

1. Child's Name: _____ Age: _____ Date of Birth: _____
2. Child's Name: _____ Age: _____ Date of Birth: _____
3. Child's Name: _____ Age: _____ Date of Birth: _____

Days of week child(ren) will attend daycare:

___Monday ___Tuesday ___Wednesday ___Thursday ___Friday



To be completed by Child Care Provider:



NAME: _____
Child Care Operation

Permit #: _____

Tax ID #: _____

___Licensed Child Care Facility

___Registered /Licensed Home Social Security # _____ - _____ - _____

Contact Person: _____

Mailing Address: _____
Street/P.O. Box

City State Zip

Phone Number: _____ Fax Number: _____

Email Address: _____

LIST COST OF CARE:

1. Child's Name: _____ \$per week: _____

2 Child's Name: _____ \$per week: _____

Signature
Director/Owner/Manager

Date