



MT. HOOD COMMUNITY COLLEGE 2009-2010 CHILDCARE SCHOLARSHIP APPLICATION

Scholarship amount: \$1,800 for Full-Time
\$1,200 for Three-quarter Time
\$600 for Half-Time

Awarded: Fall Term 2009

For use: 2009-2010 Academic Year

The MHCC Childcare Scholarship Program is designed to help eligible student parent families provide continuity of care for their child/children for one year in order to foster financial stability for the academic year. **Applications will not be accepted before October 14, 2009.**

ELIGIBILITY CRITERIA

- ❖ Student parent enrolled at MHCC taking a minimum of 6 credit hours who is not receiving other childcare subsidies.
- ❖ Demonstrated financial eligibility for childcare for children ages 6 weeks to 12 years.
- ❖ Student must meet financial aid standards of academic progress.
- ❖ Verified eligibility within USDA reduced meal guideline.
- ❖ Complete the attached Application and Childcare Verification form.

PROGRAM REGULATIONS

- ❖ Applications will be processed through a lottery system. Applications will be accepted October 14, 2009 through October 16, 2009 from the hours of 10:00 am to 5:00 pm. In a random selection process, we will draw individual numbers to be assigned to the applications. Students who have the lowest numbers drawn will have first consideration. Incomplete applications will not be considered.
- ❖ Childcare Scholarships will be granted for up to one academic year at a time to participating student parent families.
- ❖ The Office of Financial Aid will notify all applicants of MHCC Scholarship awards.
- ❖ Payment will go directly to the student. Payment will be provided to the student for subsequent terms once verification of childcare costs for the term have been submitted to the Office of Financial Aid if the student has met the standards of academic progress and is registered for the next term.
- ❖ The MHCC Childcare Scholarship Program is a childcare scholarship program for MHCC student parents and is not affiliated and does not contract with any childcare provider. MHCC does not endorse or make any recommendations regarding childcare providers. Student parents may choose any childcare provider that meets provider criteria (below) for this program and are responsible for all screening, contracting and monitoring of the childcare arrangements.
- ❖ Scholarship funds shall be divided equally between three terms. Winter and spring term funds are contingent upon student maintaining status indicated below with a minimum 2.0 G.P.A.
- ❖ Students with existing financial aid award packages may find that a scholarship award will reduce some of their existing aid. Specifics can only be determined if/when you actually receive a scholarship. Scholarship awards are contingent upon funding.

CHILD CARE EXPENSE VERIFICATION

MT. HOOD COMMUNITY COLLEGE
OFFICE OF FINANCIAL AID
26000 SE Stark St., Gresham, OR 97030
503-491-7262 FAX: 503-491-7379

APPLICANT'S NAME _____ SSN or MHCC ID# _____

ADDRESS _____ APT# _____

CITY _____ ST _____ ZIP _____ PHONE () _____

I will need assistance during: Summer Fall Winter Spring

I would not be able to attend college if I did not have this childcare for my child(ren). I receive \$ _____ per month from _____ to pay for childcare.
(Agency)

(Enter Zero if no money is provided. If zero, and you receive ADC benefits, provide current ADC statement regarding childcare subsidies.)

IF YOU HAVE MORE THAN ONE CHILD CARE PROVIDER, YOU MUST TURN IN A SEPARATE CHILD CARE EXPENSE VERIFICATION FORM FOR EACH PROVIDER.

NAMES AND AGES OF CHILDREN REQUIRING CHILD CARE:

NAME	AGE	NAME	AGE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

STUDENT SIGNATURE _____ **DATE** ____/____/____

Note: If a relative of yours or the child(rens) is the provider, or if the provider has the same address as you, you must provide copies of three months of cancelled checks or money orders.

PROVIDER SECTION

(To be completed by provider only)

PROVIDER'S NAME _____

BUSINESS NAME _____

STREET ADDRESS _____ PHONE () _____

CITY _____ STATE _____ ZIP _____

Average child care cost PER MONTH for this applicant is \$ _____

I am I am not related to the child(ren).

PROVIDER SIGNATURE _____ **DATE** ____/____/____