MONMOUTH DAY CARE CENTER
SCHOLARSHIP APPLICATION

Parent(s): ______________________________ Phone: ______________

Address: ____

Social Security #: ____

Child's Name: ____________________________ Age: ______________

Marital Status: ___________________________ Family Size: ________

Work Information

Employer: ________________________________ Phone: ____________

Address: ____

Annual Income: ____________________ (Need one month's proof of income)

Verification Attached: Paystubs __________

Room: ________________________ Regular Weekly Tuition Fee: ________

Reduction approved: ______________ Reduced Weekly Tuition Fee: ________

This reduction will be maintained for a period of one year from ________ to ________

Please advise if household income or family size changes during this time.

______________________________ ______________________
Signature of Parent Date

______________________________ ______________________
Executive Director Date