



**Application
THE WORKING PARENTS ASSISTANCE PROGRAM (WPA)
7300 Calhoun Place, Suite 600
Rockville, Maryland 20855
Montgomery County, Maryland**

Case ID# _____
Worker's Initials _____
DEADLINE DATE

TELL US ABOUT YOURSELF

Last Name		First Name		Middle Initial	Social Security No.
Street Address					Home Phone No.
City					Cell Number
Marital Status (single, married, living w/other parent)	Sex (M, F)	Date of Birth	Total Household Size	Email address	

TELL US ABOUT YOUR MATE /SPOUSE LIVING WITH YOU

Last Name		First Name		Middle Initial	Date of Birth	Mate Social Security No.
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Have you applied for WPA before?

TELL US ABOUT YOUR ACTIVITY

TELL US ABOUT YOUR MATE'S ACTIVITY

Employer Name
Address
Telephone
Days of the Week Worked
Time Schedule

Employer Name
Address
Telephone
Days of the Week Worked
Time Schedule

Name of School (IF ATTENDING)
Graduate ___ Undergraduate ___ Vocational ___ High School ___
Address
Full Time ___ Part Time ___ Current Semester _____

Name of School (IF ATTENDING)
Graduate ___ Undergraduate ___ Vocational ___ High School ___
Address
Full Time ___ Part Time ___ Current Semester _____

COMPLETE THE INFORMATION FOR ALL OF YOUR CHILDREN (INCLUDE ALL OF YOUR CHILDREN)

Name of Child	Child's Date of Birth	Sex (M, F)	Child's Social Security Number	Relation to You	Check for Part Time Care	Check for Full Time Care

COMPLETE THE INFORMATION FOR YOUR CHILDREN'S ABSENT PARENT(S) (INCLUDE ALL ABSENT PARENTS)

Name of Child	Name of Child's Absent Parent	Absent Parent's Date of Birth	Absent Parent's Social Security	Open Child Support Case or Divorce Decree with Order? Yes, No

TELL US ABOUT YOUR CHILDREN'S CHILD CARE PROVIDER

Name of Child	Provider's Name, Address and Telephone Number	Weekly Fee	Licensed? Yes or No	Start Date

LIST ALL OF YOUR SOURCES OF INCOME (Income Means Money Made/ Received)

Name of Employer(s)	Gross Income Amount Received Before Taxes	Received Weekly, Bi-Weekly, Twice Monthly, Annually?
Child Support Name the Absent Parent(s)	Amount of Child Support	Received Weekly, Bi-Weekly, Twice Monthly, Monthly?
Other Income Source (money coming into your household, ie interest, property)	Amount	Received Weekly, Bi-Weekly, Twice Monthly, Monthly, Annually?

LIST ALL OF YOUR MATE'S SOURCES OF INCOME (Income Means Money Made /Received)

Name of Employer(s)	Gross Income Amount Received Before Taxes	Received Weekly, Bi-Weekly, Twice Monthly, Annually?
Other Income Source (money coming into your household)	Amount	Received Weekly, Bi-Weekly, Twice Monthly, Monthly, Annually?

PLEASE ANSWER THE FOLLOWING QUESTIONS

Are you or any of your children receiving SSA Survivor's Benefits or Social Security Benefits from a deceased parent? _____ If yes, how much per month? \$ _____

Do any of the children for whom you need care have special needs? _____ If yes, which child? _____

Do you or your mate pay court ordered child support to a child **outside** your home? _____ If yes, how much per month? \$ _____

Are you or your mate currently pregnant? _____ If yes, due date? _____

Do you receive TCA (Temporary Cash Assistance)? _____

Are you currently receiving child care subsidy from the State's Child Care Scholarship Program? _____

How did you hear about us? _____

PLEASE READ THE FOLLOWING, SIGN AND DATE

The information I have provided on this application, and all information submitted in support of this application is true, correct and complete. I understand that I can be determined ineligible for day care subsidy for making false or incorrect statements or failing to report changes.

I understand that I have the right to appeal if I am not satisfied with the action taken on my application by the Working Parents Assistance Program. My request must be filed within ten (10) working days from the date of the notice of decision.

I hereby authorize the Working Parents Assistance Program to verify my income, checking and savings, insurance, shelter or disability benefits, and any and all other facts pertinent to my eligibility for child care subsidy.

I hereby give The Working Parents Assistance Program permission to give my licensed provider information regarding the status of my application.

I hereby give The Working Parents Assistance Program permission to contact me by telephone, text or email.

(Please check one: yes ___ no ___)

Applicant's
Signature _____ Date _____

Co-Applicant's
Signature _____ Date _____

Case Worker's
Signature _____ Date _____

***RETURN BY EMAIL wpa@montgomerycountymd.gov