APPLICATION FOR
THE WORKING PARENTS ASSISTANCE PROGRAM (WPA)
7300 Calhoun Place Suite 700
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	MARYLAND	Zip Code	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***

Have you applied for WPA subsidy before?

Last Name	First Name	Middle Initial	Date of Birth	Mate's Social Security No.

TELL US ABOUT YOUR ACTIVITY	TELL US ABOUT YOUR MATE'S ACTIVITY
Employer Name	Employer Name
Address	Address
Telephone	Telephone
Days of the Week Worked	Days of the Week Worked
Time Schedule	Time Schedule
Name of School (IF ATTENDING)	Name of School (IF ATTENDING)
Graduate ____ Undergraduate ___ Vocational ___ High School ___	Graduate ____ Undergraduate ___ Vocational ___ High School ___
Address	Address
Full Time ____ Part Time ____ Current Semester _____	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

EG9/5/18

PLEASE CONTINUE ON 2nd Page ☞

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 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 Subsidy Program? _____

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 FAX (240) 777-1342, and/or EMAIL wpa@montgomerycountymd.gov*****