Rhode Island Department of Human Services
Child Care Assistance Training Verification and Change Reporting Form

- ☐ Initial Application
- ☐ Change

BACKGROUND INFORMATION

APPLICANT NAME (Head of Household)	SOCIAL SECURITY NUMBER
Phone Number Where You Can Be Reached Between 8:30AM-4PM	☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Single
ADDRESS Number Street City/Town State Zip	
MAILING ADDRESS (if different from above)	

TRAINING

Funding Source (ex. DLT, GWB, RIDE, DHS)	
Training Provider/Agency	
Type of Training	

TRAINING DATES

Scheduled start date	
Scheduled end date	

HOURS OF TRAINING

Training Schedule	Start Time	End Time
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Signature of Agency/Program Representative	Date
Signature of DHS Representative	Date