

Initial Application

Update



**MENDOCINO COUNTY
CENTRALIZED ELIGIBILITY LIST**
Application for Subsidized Child Care Services

Mail:

Fax:
PHONE:

PLEASE RETURN THIS FORM TO:

CEL Coordinator
NCO/Rural Communities Child Care
413 N. State St. Ukiah, CA 95482
707-467-3216
800-606-5550 Ext. 229

1. FIRST PARENT/GUARDIAN INFORMATION

Name of Parent _____

Home Phone _____

Mailing Address _____

Work Phone _____

Physical Address _____

Alternate Phone _____

City _____ Zip Code _____

Parent Date of Birth _____

What is your relationship to the children needing care?

Mother Father Grandparent Guardian Foster Parent Other _____

Are you: Employed? Yes No **If Yes:** Name of employer _____

Zip code of employer _____ How many hours per week do you work? _____

In school/training? Yes No **If Yes:** Name of school or program _____

Zip Code of school or program _____

Characteristics: Please if you are: Looking for work Incapacitated Teen parent

Seasonal/Migrant Worker Homeless/Seeking Permanent Housing: List Shelter Program _____

Is this a CPS/At Risk Referral? If Yes Attach Referring Agency Information

Signature: _____

Date: _____

2. SECOND PARENT/GUARDIAN INFORMATION (only if this is a two parent household)

Name of Parent: _____

Home Phone () _____

Work Phone () _____

Parent Date of Birth _____

What is your relationship to the children needing care?

Mother Father Grandparent Guardian Foster Parent Other _____

Are you: Employed? Yes No **If Yes:** Name of employer _____

Zip code of employer _____ How many hours per week do you work? _____

In school/training? Yes No **If Yes:** Name of school or program _____

Zip Code of school or program _____

Characteristics: Please if you are:

Looking for work Incapacitated Teen parent Migrant Worker

3. PREFERENCES

AREA PREFERENCE (If more than one, please indicate 1st 2nd 3rd choice)

_____ Ukiah & Surrounding Areas _____ Willits & Surrounding Areas _____ South Coast _____ North Coast

PROGRAM PREFERENCE:

Please refer to the attached "Subsidized Program Descriptions" and check one of the following:

State Preschool or other Center Based Program Alternative Payment Program (can include NET in Ukiah)

After-school Program Other _____

IMPORTANT: Please complete additional information on reverse side

FOR CEL OFFICE USE ONLY:

Date Application Received: _____

Rank: _____

Family ID #: _____

Data Entry Completed by: _____

Date: _____

4. CHILD INFORMATION (for every child living in your household)

NAME	DATE OF BIRTH	Schedule of Care Needed Please <input checked="" type="checkbox"/>							
		SERVICES NEEDED		FULL TIME	PART TIME	EVENING	OVERNIGHT	WEEKEND	HOURS NEEDED
		YES	NO						
1.									
2.									
3.									
4.									
5.									
6.									
7.									

Total Number of Family Members In Household _____

Are children currently receiving services? Yes No If yes, list child(ren) _____

Child/ren are enrolled at:

Head Start or State Preschool APP Program NET CDE Centers CDE After-School Program

Please if any of the following apply to any of these children:

Exceptional Needs (has an IEP or IFSP) Limited English Proficient Name of Child _____

5. ADDITIONAL COMMENTS

6. FAMILY INCOME

Have you ever received cash aid through the Department of Social Services within the past 24 months? Yes No

If Yes, what was the last month and year you received a check? _____ Case Number _____

Was this for the child (ren) ONLY _____ or BOTH Parent and child (ren) _____

1 st Parent/Guardian		2 nd Parent/Guardian		PLEASE NOTE: Completion of this application is NOT a guarantee for services. Your placement on the CEL is based on an eligibility rank system. Your total gross income and the number of people in your family unit determine your rank number. Families with the lowest rank number will be contacted first when an opening becomes available. The CEL does not discriminate on the basis of sex, sexual orientation, gender, ethnic group identification, race, ancestry, national origin, religion, color, or mental or physical disability in determining which families will be served. At the time of enrollment you are required to provide the following: A) Current 30 days of income B) Birth Certificates C) Immunization records
Gross Employment Wages or Salary:	\$	Gross Employment Wages or Salary	\$	
Rate x Hours x 52 weeks divided by 12		Rate x Hours x 52 weeks divided by 12		
Spousal/Child Support received	\$	Spousal/Child Support received	\$	
Spousal/Child Support paid	\$	Spousal/Child Support paid	\$	
Self-Employment	\$	Self-Employment	\$	
Unemployment/Disability	\$	Unemployment/Disability	\$	
Veterans	\$	Veterans	\$	
Pensions	\$	Pensions	\$	
Workers Compensation	\$	Workers Compensation	\$	
Foster Income	\$	Foster Income	\$	
Cash Aid	\$	Cash Aid	\$	
CalWORKS State Only (TANF-MOE)	\$	CalWORKS State Only (TANF-MOE)	\$	
Housing Voucher or Cash	\$	Housing Voucher or Cash	\$	
Food Stamps	\$	Food Stamps	\$	
SSI/SSP/SSA	\$	SSI/SSP/SSA	\$	
TOTAL GROSS MONTHLY INCOME	\$	TOTAL GROSS MONTHLY INCOME	\$	