4Cs Sonoma County
131-A Stony Circle • Suite 300 | Santa Rosa, CA 95401 | Office (707) 544-3077 | Fax (707) 544-2625 www.sonoma4Cs.org

WAITLIST APPLICATION FORM

1. FAMILY INFORMATION

Do you or your child(ren) currently participate in any of the following assistance programs?
☐Medi-Cal,
☐CalFresh
If you do receive CalFresh, please enter your case number _____,
☐California Food Assistance Program,
☐California Special Supplemental Nutrition Program for Women, Infants, and Children (WIC: Women, Infants, and Children),
☐The Federal Food Distribution Program on Indian Reservations,
☐Head Start,
☐Early Head Start,
☐CalWORKs
If you receive or have recently received CalWORKs, please enter your case number _____,
☐Other _____

Do you receive Cash Aid from your county?
☐Currently Receiving Cash Aid
Which County did you receive Cash Aid from? _____
☐Terminated from Cash Aid; no longer receiving Cash Aid.
Termination Date _____
☐Never Received Cash Aid

Family Type
☐Biological/Adoptive ☐Guardianship ☐Foster
If you need assistance for guardianship or foster child(ren), please submit a separate application.

☐Homeless ☐Single Parent ☐Sibling Enrolled

Are your children:
☐Child Protective Services
☐At Risk as defined by the Department of Social Services
☐Working with the Department of Children and Family Services

How did you hear about us?
☐Email ☐Child Care Provider ☐Internet/Agency Website ☐Advertisement/Flyer ☐Friend/Relative
☐Child Welfare/Other Social Service Agency ☐On Site Referral ☐Other

2. PARENT/GUARDIAN INFORMATION

A. PARENT/GUARDIAN "A"

First Name:	Middle Name:	Last Name:	DOB:
Race: ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐Caucasian ☐Hispanic or Latino			Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino
Physical Address:	City:	Zip Code:	State:
Mailing Address (If Different from Physical):	City:	Zip Code:	State:
Email:	Cell Phone:	Additional Phone:	
Preferred Contact Method: ☐Email ☐SMS	Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed	Preferred Language: ☐English ☐Spanish ☐Cantonese ☐Mandarin ☐Other	
Relationship to Child: ☐Father ☐Mother ☐Step-Parent ☐Grandparent ☐Legal Guardian ☐Foster Parent ☐Other			

REASON FOR SERVICES (Check all that apply)

☐ Working (Employed/Self-Employed)
Company Name _______________ Phone Number _______________ Company Email _______________
☐ Seeking Employment
☐ Attending School/Vocational Training, School Name _______________ # of Units _______________
☐ Medically Incapacitated, what are your probable dates of incapacitation? _______________
☐ Currently Experiencing Homeless or Seeking Permanent Housing, (if you are staying with friends, family, or a shelter, please check this option to help us find additional child care options.)
☐ Emergency Need for Child Care
☐ Referred to Child Care by a Social Worker
☐ Seeking Part-Day Preschool

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☐ Neighborhood School Eligibility
☐ None Applicable
☐ Other

B. PARENT/GUARDIAN "B" (ONLY IF LIVING IN THE HOME WITH THE CHILD/REN)

First Name:	Middle Name:	Last Name:	DOB:
Race: ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐Caucasian ☐Hispanic or Latino			Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino
Email:	Cell Phone:	Additional Phone:	
Preferred Contact Method: ☐Email ☐SMS	Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed	Preferred Language: ☐English ☐Spanish ☐Cantonese ☐Mandarin ☐Other	
Relationship to Child: ☐Father ☐Mother ☐Step-Parent ☐Grandparent ☐Legal Guardian ☐Foster Parent ☐Other			

REASON FOR SERVICES (Check all that apply)

☐ Working (Employed/Self-Employed)
Company Name ________________ Phone Number ________________ Company Email ________________
☐ Seeking Employment
☐ Attending School/Vocational Training, School Name ________________ # of Units ________________
☐ Medically Incapacitated, What are your probable dates of incapacitation? ________________
☐ Currently Experiencing Homeless or Seeking Permanent Housing (If you are staying with friends, family, or a shelter, please check this option to help us find additional child care options)
☐ Emergency Need for Child Care
☐ Referred to Child Care by a Social Worker
☐ Seeking Part-Day Preschool
☐ Neighborhood School Eligibility
☐ None Applicable
☐ Other

3. FAMILY INCOME

Family Size:	Monthly Estimated Family Total Income Before Tax: $
PARENT "A" MONTHLY INCOME (Before Tax)	
Employment/Self-employment: $ (If your employment is variable, please provide an average monthly gross amount)	
Business Expenses (for Self-Employment only): $	Unemployment: $
Disability: $	Public Assistance/TANF/Cash Grant: $
CalWORKs Cash Aid (Family): $	CalWORKs Cash Aid (Children only): $
Spousal Support Received: $	Disability: $
Disability: $	Child Support Received: $
Child Support Payout: $	Foster Care: $
Social Security/SSA (Parent): $	Social Security/SSA (Children only): $
SSI/SSP (Parent): $	SSI/SSP (Children only): $
Military Income (BAH, BAS, or other entitlements): $	Other Income: $
Parent A's Total Monthly Income: $	
PARENT "B" MONTHLY INCOME (Before Tax)	
Employment/Self-employment: $ (If your employment is variable, please provide an average monthly gross amount)	
Business Expenses (for Self-Employment only): $	Unemployment: $
Disability: $	Public Assistance/TANF/Cash Grant: $
CalWORKs Cash Aid (Family): $	CalWORKs Cash Aid (Children only): $
Spousal Support Received: $	Disability: $
Disability: $	Child Support Received: $

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Child Support Payout: $	Foster Care: $
Social Security/SSA (Parent): $	Social Security/SSA (Children only): $
SSI/SSP (Parent): $	SSI/SSP (Children only): $
Military Income (BAH, BAS, or other entitlements): $	Other Income: $
Parent B's Total Monthly Income: $	

4. CHILDREN INFORMATION

CHILD #1

First Name:	Middle Name:	Last Name:
DOB:	Gender:	Relationship to Parent: ☐Son ☐Daughter ☐Adopted ☐Foster ☐Other

My child has special needs. (Check all that apply):
☐ My child has an Individualized Education Plan (IEP)
☐ My child has an Individualized Family Service Plan (IFSP)
☐ My child receives Supplemental Security Income (SSI)
☐ I have developmental concerns about my child.

Race: ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐Caucasian ☐Hispanic or Latino	Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino
Is the Primary Home Language, a language other than English: ☐Yes ☐No	Child Language: ☐English ☐Spanish ☐Cantonese ☐Mandarin ☐Other ______
Allergies: ☐Dairy ☐Eggs ☐Meats ☐Nuts ☐Seafood ☐Soy ☐Other	Medications: ______
Diet Restrictions: ☐Yes ☐No	Additional details about the child's allergies, medications, or additional health concerns:

CHILD #2

First Name:	Middle Name:	Last Name:
DOB:	Gender:	Relationship to Parent: ☐Son ☐Daughter ☐Adopted ☐Foster ☐Other

My child has special needs. (Check all that apply):
☐ My child has an Individualized Education Plan (IEP)
☐ My child has an Individualized Family Service Plan (IFSP)
☐ My child receives Supplemental Security Income (SSI)
☐ I have developmental concerns about my child.

Race: ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐Caucasian ☐Hispanic or Latino	Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino
Is the Primary Home Language, a language other than English: ☐Yes ☐No	Child Language: ☐English ☐Spanish ☐Cantonese ☐Mandarin ☐Other ______
Allergies: ☐Dairy ☐Eggs ☐Meats ☐Nuts ☐Seafood ☐Soy ☐Other	Medications: ______
Diet Restrictions: ☐Yes ☐No	Additional details about the child's allergies, medications, or additional health concerns:

CHILD #3

First Name:	Middle Name:	Last Name:
DOB:	Gender:	Relationship to Parent: ☐Son ☐Daughter ☐Adopted ☐Foster ☐Other

My child has special needs. (Check all that apply):
☐ My child has an Individualized Education Plan (IEP)
☐ My child has an Individualized Family Service Plan (IFSP)
☐ My child receives Supplemental Security Income (SSI)
☐ I have developmental concerns about my child.

Race: ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐Caucasian ☐Hispanic or Latino	Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino
Is the Primary Home Language, a language other than English: ☐Yes ☐No	Child Language: ☐English ☐Spanish ☐Cantonese ☐Mandarin ☐Other ______
Allergies: ☐Dairy ☐Eggs ☐Meats ☐Nuts ☐Seafood ☐Soy ☐Other	Medications: ______
Diet Restrictions: ☐Yes ☐No	Additional details about the child's allergies, medications, or additional health concerns:

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CHILD #4		
First Name:	Middle Name:	Last Name:
DOB:	Gender:	Relationship to Parent: Son Daughter Adopted Foster Other

My child has special needs. (Check all that apply):
- My child has an Individualized Education Plan (IEP)
- My child has an Individualized Family Service Plan (IFSP)
- My child receives Supplemental Security Income (SSI)
- I have developmental concerns about my child.

Race: American Indian or Alaskan Native Asian Black or African American Native Hawaiian or Other Pacific Islander Caucasian Hispanic or Latino	Ethnicity: Not Hispanic or Latino Hispanic or Latino
Is the Primary Home Language, a language other than English: Yes No	Child Language: English Spanish Cantonese Mandarin Other ______

Allergies: Dairy Eggs Meats Nuts Seafood Soy Other	Medications: ______	Diet Restrictions: Yes No

Additional details about the child's allergies, medications, or additional health concerns:

5. CHILD CARE CRITERIA

Do you need help choosing child care providers? Yes No

Child Name(s):	Child Care Start Date:
Preferred Provider Language:	Preferred Provider Types: Licensed Family Child Care Home Licensed Child Care Center Family, Friend, or Neighbor

DESIRED CARE SCHEDULE

Set Schedule (Days of care are the same week to week), fill out the hours in table below

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
From: AM / PM	From: AM / PM	From: AM / PM	From: AM / PM	From: AM / PM	From: AM / PM	From: AM / PM
To: AM / PM	To: AM / PM	To: AM / PM	To: AM / PM	To: AM / PM	To: AM / PM	To: AM / PM

Variable Schedule (Days of care changes week to week)
The maximum # of days the child(ren) would need care per week: ______; maximum # of hours needed per week:______

PREFERRED PROVIDER (If you have specific provider(s) in mind, you may add them in any order)

Provider Name and/or Address:

Provider Name and/or Address:

Provider Name and/or Address:

6. CONFIRMATION

I declare that, to the best of my knowledge and belief, the information provided is true and correct. I agree to notify the agency immediately if there are any changes to the information contained in this form. I understand the information I have provided is confidential and will be used only to determine my eligibility for child care services and establish my priority on the waiting list. I further understand that all of the information I have provided will be verified before I may be approved for services.

Signature:	Sign Date:

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