4Cs Sonoma County

CHILDCARE ELIGIBILITY LIST (CEL)

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)

Mail your completed form to: 4Cs of Sonoma County 131-A Stony Circle, Suite 300 Santa Rosa, CA 95401
Or fax your completed form to: (707) 544-2625 Sonoma CEL, Or email your completed form to: info@sonoma4cs.org
Or complete online:

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

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: $**
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:

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:**

Mail your completed form to: 4Cs of Sonoma County 131-A Stony Circle, Suite 300 Santa Rosa, CA 95401
Or fax your completed form to: (707) 544-2625 Sonoma CEL, Or email your completed form
to: info@sonoma4cs.org Or complete online: https://app.mycareconnect.io/family/4cs