



Child Development Consortium of Los Angeles

non profit corporation

1930 Wilshire Blvd. Suite #602
 Los Angeles, CA 90057
 (213) 353-1600 Fax (213) 353-0795

Application for Services with the Child Development Consortium of Los Angeles

The Child Development Consortium of Los Angeles is dedicated to helping connect low-income families with child care as child care spaces available. By completing this form, you will be placed on our waiting list for child care services. The information you provide on this form will help determine your eligibility for services and allows us to contact you if and when a child care space becomes available. Per the California Department of Education all child care applications are ranked by income at the time of application submission and are not processed on a first come first served basis. Our program staff will verify the information you provided on this form to make sure you are eligible before you are invited to enroll your child. All information is handled confidentially.

COMPLETE BOTH SIDES OF FORM

Application Date: _____

Any application that is incomplete will be returned

Indicate if your household is a <input type="checkbox"/> Single parent family <input type="checkbox"/> Two parent family <input type="checkbox"/> Foster Parent		
PARENT/GUARDIAN #1		
Last name:		First name:
Street address:		City: Zip Code:
Home phone:	Cell Phone:	Primary language:
Email Address:		
Name & Address of Employer or School (City and Zip)		Work/ School Phone:
PARENT/GUARDIAN #2 INFORMATON (Complete only if there is another parent/guardian residing in the same home.)		
Last name:		First name:
Name & Address of Employer or School (City and Zip)		Work/ School Phone:
CALWORKs PARTICIPATION (Cash aid)		
Are you currently receiving cash aid? <input type="checkbox"/> Yes <input type="checkbox"/> No	If NO , have you received cash aid within the last two years? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES , last date of cash aid payment: _____/_____/_____
REASON FOR NEEDING CHILD CARE (Check all that apply.)		
	Parent/Guardian #1	Parent/Guardian #2
Working	<input type="checkbox"/>	<input type="checkbox"/>
Attending School or Job Training	<input type="checkbox"/>	<input type="checkbox"/>
Medically Incapacitated/Disabled	<input type="checkbox"/>	<input type="checkbox"/>
Looking for Work	<input type="checkbox"/>	<input type="checkbox"/>
Homeless/Seeking housing	<input type="checkbox"/>	<input type="checkbox"/>
Migrant Worker	<input type="checkbox"/>	<input type="checkbox"/>
Part-day preschool for child	<input type="checkbox"/>	<input type="checkbox"/>
FOSTER CARE PAYMENTS		
Are you currently receiving foster care payments for any of the child listed above? Check child and write the monthly amount. <input type="checkbox"/> Child # 1 \$ _____ <input type="checkbox"/> Child # 2 \$ _____ <input type="checkbox"/> Child # 3 \$ _____		

MONTHLY INCOME AND SOURCES (Enter total dollars, before taxes, for each source of income for parents/guardians in the household.)

	Parent/Guardian #1	Parent/Guardian #2
Work/Employment	\$	\$
Child Support	\$	\$
Spousal Support	\$	\$
State Disability	\$	\$
Unemployment benefits	\$	\$
Sales/Work Commissions	\$	\$
Cash Aid (CalWORKs)	\$	\$
Worker's Compensation	\$	\$
Social Security	\$	\$
SSI/SSP	\$	\$
Other (explain):	\$	\$

CHILDREN LIVING AT HOME (All children under 18 who are members of the family. Attach an additional page, if needed.)

First and Last Name	Gender (circle)	Date of Birth MM/DD/YYYY	Check only if child care is needed.			
			Full-time	Part-time	Evenings /Wkends	Y=Hispanic N=all other
#1.	F M		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
#2.	F M		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
#3.	F M		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
#4.	F M		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
#5.	F M		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
#6.	F M		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

PREFERRED LOCATION OR PROGRAM (List below your preferred zip code location. List the name of the program you prefer your child.)

Child #1	Zip Code:	Name of Program/Agency:
Child #2	Zip Code:	Name of Program/Agency:
Child #3	Zip Code:	Name of Program/Agency:

School Age Children (Complete for school age children only.)

Child # _____	Grade: _____	Name of School/School District:
Child # _____	Grade: _____	Name of School/School District:
Child # _____	Grade: _____	Name of School/School District:

RACE AND ETHNICITY (Check all that apply for child considered for enrollment in child care services)

	Alaskan Native American Indian	Asian	Black African American	Native Hawaiian Other	Caucasian	Pacific Islander
Child #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child #2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child #3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SPECIAL NEEDS (Check all that apply)

	Child # 1	Child # 2	Child # 3
Child Protective Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child has IFSP (Individual Family Service Plan) or IEP (Individual Education Plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child receives services through Regional Center or the local School District	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social emotional/behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ongoing health problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental delays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech/communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision or hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please explain):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OFFICE USE ONLY

Date Application was Received:	Date Parent was Called:	Outcome:
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