



## Connections For Children Eligibility List

Registration Form

By completing this form, you are registering on the Connections For Children (CFC) Eligibility List for low-income families. The information you provide determines your eligibility for subsidized child care and development services as spaces and funding become available. When your family is contacted for enrollment, you will have to document the information provided on this form to make sure you are eligible before you enroll your child. **All information is confidential.** For more information, please feel free to contact CFC at (310) 452-3325 or visit our Website at [www.connectionsforchildren.org](http://www.connectionsforchildren.org).

Parent/Guardian #1 Information (Must provide information on ALL adults in the household)		
Last Name:	First name:	Primary language:
Street Address:	City:	Zip code:
Home phone:	Work phone:	Cell phone:
Email Address:		
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)	
<input type="checkbox"/> Working (Employer's Name/Zip Code: _____) <input type="checkbox"/> Attending School or Job Training (Name of School/Zip code: _____) <input type="checkbox"/> Medically Incapacitated/Disabled	<input type="checkbox"/> Looking for Work <input type="checkbox"/> Homeless/Seeking Housing <input type="checkbox"/> Part-day preschool experience for child Only <input type="checkbox"/> Migrant Worker

INCOME (Write total dollars, BEFORE taxes and deductions, for each source of income)					
Monthly Income	Source	Monthly Income	Source	Monthly Income	Source
	Wages/salaries or income from self-employment		Spousal Support		Food Stamps
	Social Security Benefits		State Disability		Unemployment benefits
	Worker's Compensation		Child Support		Pensions/Annuities
	State Supplemental Income		Adoption Subsidies		Cash Aid (Children Only)
	Other:		If you pay out child support, how much is it per month?		

Parent/Guardian #2 Information (Must provide information on ALL adults in the household)		
Last Name:	First name:	Primary language:
Street Address:	City:	Zip code:
Home phone:	Work phone:	Cell phone:
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)	
<input type="checkbox"/> Working (Employer's Name/Zip Code: _____) <input type="checkbox"/> Attending School or Job Training (Name of School/Zip code: _____) <input type="checkbox"/> Medically Incapacitated/Disabled	<input type="checkbox"/> Looking for Work <input type="checkbox"/> Homeless/Seeking Housing <input type="checkbox"/> Part-day preschool experience for child Only <input type="checkbox"/> Migrant Worker

INCOME (Write total dollars, BEFORE taxes and deductions, for each source of income)					
Monthly Income	Source	Monthly Income	Source	Monthly Income	Source
\$	Wages/salaries or income from self-employment	\$	Spousal Support	\$	Food Stamps
\$	Social Security Benefits	\$	State Disability	\$	Unemployment benefits
\$	Worker's Compensation	\$	Child Support	\$	Pensions/Annuities
\$	State Supplemental Income	\$	Adoption Subsidies	\$	Cash Aid (Children Only)
\$	Other:	\$	If you pay out child support, how much is it per month?		

**CHILDREN LIVING AT HOME (All children in the household under the age of 18 or under age 22 if disabled)**

#1 First Name		Last Name	
Birth Date:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Preferred Zip Code for care:	
<b>Care Needed: (Check all schedules that apply)</b> <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends <input type="checkbox"/> None			
Child School Name/ Grade:		District:	
<b>IF CHILD IS IN CHILD PROTECTIVE SERVICES PLEASE COMPLETE HERE</b>			
Foster Care Payment	Social Worker's Name	Contact Number	Case Number
\$			
At risk of Abuse, Neglect or Exploitation? (Must have a referral) <input type="checkbox"/> Yes <input type="checkbox"/> No Referred by: _____		List related siblings in the same household:	
"Parents" Relationship To This Child: <input type="checkbox"/> Biological <input type="checkbox"/> Foster <input type="checkbox"/> Guardian <input type="checkbox"/> Adoptive <input type="checkbox"/> Other:			

#2 First Name		Last Name	
Birth Date:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Preferred Zip Code for care:	
<b>Care Needed: (Check all schedules that apply)</b> <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends <input type="checkbox"/> None			
Child School Name/ Grade:		District:	
<b>IF CHILD IS IN CHILD PROTECTIVE SERVICES PLEASE COMPLETE HERE</b>			
Foster Care Payment	Social Worker's Name	Contact Number	Case Number
\$			
At risk of Abuse, Neglect or Exploitation? (Must have a referral) <input type="checkbox"/> Yes <input type="checkbox"/> No Referred by: _____		List related siblings in the same household:	
"Parents" Relationship To This Child: <input type="checkbox"/> Biological <input type="checkbox"/> Foster <input type="checkbox"/> Guardian <input type="checkbox"/> Adoptive <input type="checkbox"/> Other:			

#3 First Name		Last Name	
Birth Date:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Preferred Zip Code for care:	
<b>Care Needed: (Check all schedules that apply)</b> <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends <input type="checkbox"/> None			
Child School Name/ Grade:		District:	
<b>IF CHILD IS IN CHILD PROTECTIVE SERVICES PLEASE COMPLETE HERE</b>			
Foster Care Payment	Social Worker's Name	Contact Number	Case Number
\$			
At risk of Abuse, Neglect or Exploitation? (Must have a referral) <input type="checkbox"/> Yes <input type="checkbox"/> No Referred by: _____		List related siblings in the same household:	
"Parents" Relationship To This Child: <input type="checkbox"/> Biological <input type="checkbox"/> Foster <input type="checkbox"/> Guardian <input type="checkbox"/> Adoptive <input type="checkbox"/> Other:			

#4 First Name		Last Name	
Birth Date:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Preferred Zip Code for care:	
<b>Care Needed: (Check all schedules that apply)</b> <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends <input type="checkbox"/> None			
Child School Name/ Grade:		District:	
<b>IF CHILD IS IN CHILD PROTECTIVE SERVICES PLEASE COMPLETE HERE</b>			
Foster Care Payment	Social Worker's Name	Contact Number	Case Number
\$			
At risk of Abuse, Neglect or Exploitation? (Must have a referral) <input type="checkbox"/> Yes <input type="checkbox"/> No Referred by: _____		List related siblings in the same household:	
"Parents" Relationship To This Child: <input type="checkbox"/> Biological <input type="checkbox"/> Foster <input type="checkbox"/> Guardian <input type="checkbox"/> Adoptive <input type="checkbox"/> Other:			

CHILDREN WITH SPECIAL NEEDS, DISABILITIES OR MEDICAL CONDITIONS				
Check all that apply for each child listed above	Child #1	Child #2	Child #3	Child #4
Child has Individual Family Services Plan (IFSP) (age 0-3)				
Child has an Individual Education Plan (IEP) (ages 3 and older)				
Receives Early Start/Regional Center services				
Receives services from local school district (special education)				
Developmental delays (cognitive, autism, Down Syndrome, etc.)				
Developmental delays (physical/motor)				
Social/Emotional delays or behavior				
Physical disability (cerebral palsy, spinal bifida, orthopedic limitations, etc.)				
Health/medical (asthma, diabetes, other _____)				
Speech/language/communication				
Hearing/vision				

**I certify through my signature that the information on this form is true and correct to the best of my knowledge.**

\_\_\_\_\_  
Name of Parent/Guardian

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date