

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.

	Parent/Guardian #1 Inform	ation (Must p	provide inform	nation on ALL adu	ults in the	e househo	ld)							
Last Name:		First name:			Primary language:									
Street Addres	ss:	City:			Zip code:									
Home phone	e:	Work phone	Work phone:			Cell phone:								
Email Addre	ess:													
Are you curre	ently receiving cash aid? 🗌 Yes 🔲 N	lo If NO, hav	ve you receive	ed cash aid within th	e last two	o years?	Yes No							
If YES last dat	If YES last date of cash aid payment://													
经长品的	REASON FO	R NEEDING (CHILD CARE (Check all that ap	ply)									
☐ Working	g (Employer's Name/Zip Code:)					Looking for	r Work							
Attendin	g School or Job Training (Name of Scl					Seeking Housing								
☐ Medica	lly Incapacitated/Disabled	oreschool experience for child Only Migrant Worker												
	INCOME (Write total dollar	rs, BEFORE ta			source									
Monthly Income	Source		Monthly Income	Source		Monthly Income	Source							
	Wages/salaries or income from self-emplo	oyment		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 Inform	ation (Must p	orovide infor	mation on ALL adu	ults in the	e househo	ld)							
Last Name:		First name:		Primary language:										
Street Addre	ss:	City:			Zip code:									
Home phone	9:	Work phone:			Cell phone:									
Are you curre	ently receiving cash aid? \(\square\) Yes \(\square\) \(\lambda\)	No If NO, hav	ve you receive	ed cash aid within th	ne last tw	o years? 🗌	Yes No							
1	te of cash aid payment:/													
	REASON FO	R NEEDING	CHILD CARE	(Check all that ap	ply)									
☐ Working (Employer's Name/Zip Code:) ☐ Looking for Work														
☐ Attending School or Job Training (Name of School/Zip cod			e:			☐ Homeless/Seeking Housing								
☐ Medica	Illy Incapacitated/Disabled	Part-day	oreschool exp	erience for child On	nly 🗌	Migrant W	orker							
	INCOME (Write total dolla	rs, BEFORE to												
Monthly Income	Source		Monthly Income	Source		Monthly Income	Source							
\$	Wages/salaries or income from self-employment		\$	Spousal Support		5	Food Stamps							
\$	Social Security Benefits		\$	State Disability		j	Unemployment benefits							
\$	Worker's Compensation		\$	Child Support		5	Pensions/Annuities							
\$	State Supplemental Income		\$	Adoption Subsidies		5	Cash Aid (Children							
1			1	Adoption subsidie	, 1 t		Only)							

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

#1 First Name	Last N	#2 First Name Last Name									
Birth Date:	Gender:	Preferred Zip Code for care:		Birth Date:	Gender:	□ M		Preferred Zip Code for care:			
Care Needed: (Chec	k all schedules tha	apply)		Care Needed: (Care Needed: (Check all schedules that apply)						
☐ Full time	☐ Part time	☐ Full time									
	None	☐ Weekends									
Child School Name/	Grade: Dis	trict:		Child School Na	me/ Grade:	District	:				
	HILD PROTECTIVE SI		OMPLETE HERE	IF CHILD IS	IN CHILD PROTE	CTIVE SERVI	CES PLEASE C	OMPLETE HERE			
Foster Care Payment	Social Worker's Name	Contact Number	Case Number	Foster Care Payment	Social Work	ker's	Contact Number	Case Number			
\$	Nume	Nomber		\$	Nume		Number				
At risk of Abuse, Neg (Must have a referral Referred by:) Yes N	(Must have a re	At risk of Abuse, Neglect or Exploitation? (Must have a referral) Yes No Referred by:								
"Parents" Relationshi	p To This Child: Foster 🔲 Gu	onship To This Ch	nild: Guardia	an 🗆 Add	optive Other:						
#3 First Name	Name Last Name			#4 First Name		Last Name					
Birth Date:	Gender:	Preferred	Zip Code for care:	Birth Date:	Gender:		Preferred Zip Code for care:				
Care Needed: (Ched		t apply)		Care Needed: (Check all schedules that apply)							
☐ Full time	Part time	☐ Evenings		☐ Full time	☐ Part tim	ne 🗆] Evenings				
_		L troimigs		☐ Weekends	☐ None						
☐ Weekends Child School Name/	Orade: Di	strict:			Child School Name/ Grade: District:						
				IF CHIED IS IN CHIED BROTECTIVE SERVICES BLEAST COMBIETE HERE							
Foster Care	CHILD PROTECTIVE S Social Worker's	Contact	COMPLETE HERE Case Number	Foster Care	FOSTER CARE SOCIAL WORKER'S NAME CONTACT CASE NUMBER FOSTER CASE NUMBER FOSTER CASE NUMBER FOSTER CASE NUMBER						
Payment	Name	Number	Case Nomber	Payment			Number				
\$				\$							
At risk of Abuse, Neglect or Exploitation? (Must have a referral) Yes No household: Referred by:				(Must have a re	At risk of Abuse, Neglect or Exploitation? (Must have a referral) Yes No Referred by:						
"Parents" Relationsh	"Parents" Relati	"Parents" Relationship To This Child: ☐ Biological ☐ Foster ☐ Guardian ☐ Adoptive ☐ Other									
			17.1 BEST 1								
		CHILDREN	IITH CDECIAL MEEDS I	DISABILITES OD MEDIO	CAL CONDITIO	INIC	Personal Section				
CHILDREN WITH SPECIAL NEEDS, DISABILITES OR MEDIC Check all that apply for each child listed above						Child #2	Child #3	3 Child #4			
Child has Individual Family Services Plan (IFSP) (age 0-3)											
Child has an Individu	ual Education Plan	(IEP) (ages 3 and	lolder								
Receives Early Start/	rvices										
Receives services from local school district (special education)											
Developmental delays (cognitive, autism, Down Syndrome, etc.)											
Developmental dela	ays (physical/motor)									
Social/Emotional de	lays or behavior										
Physical disability (cerebral palsy, spinal bifida, orthopedic limitations, etc.)											
Health/medical (asthma, diabetes, other)											
Speech/language/	communication										
Hearing/vision											
I certi	ify through my	signature tha	t the information o	n this form is true o	and correct t	o the bes	t of my kno	owledge.			
		5050					-				

Signature of Parent/Guardian

Date

Name of Parent/Guardian