



Application can be
**Mailed, Faxed or
Emailed.**

Mail: 4C Council
c/o CEL Program
2515 N. First St.
San Jose, CA 95131

Fax: (408) 487-0762
Email: celinfo@4c.org

Contact information
Web: www.santaclaracountycel.org
Phone: (877) 235-0095

Centralized Eligibility List (CEL) Application

For Subsidized Child Care or Preschool in Santa Clara County

OFFICE USE ONLY: Intake Update • R&R 877# CalWORKS • FCSAD CCSAD • Rank ____ ID ____

PRIMARY PARENT

Relationship to child: Parent Grandparent Foster Parent Legal Guardian Other:

Date: _____ Primary Parent Name: _____ Preferred zip codes: (1) _____ (2) _____ (3) _____

Current address: _____ Apartment/Unit: _____ County: _____

City: _____ State: _____ Zip Code: _____

Home Phone: () _____ Cell: () _____ Work: () _____

Email: _____ Language: _____ Ethnicity: _____

Family Size (include parents & children): _____ SSN: _____ Date of birth: _____

SECONDARY PARENT not applicable

Secondary Parent Name: _____ Date of birth: _____

SSN: _____ Cell: () _____ Work: () _____

Email: _____ Language: _____ Ethnicity: _____

FAMILY INFORMATION

Characteristics (check all that apply): Teen Parent Seasonal Migrant Worker Child Protective Services Other:

Marital Status (check one): Single Married Separated Divorced Widowed

Housing (check all that apply): Currently homeless Living in a shelter None

Are you a Community College or University Student? Yes No *If yes, name of school:* _____

REASON FOR CARE - PRIMARY PARENT

Working (my work zip code: _____) Attending School/Training (my school zip code: _____)

Looking for Work Medically Incapacitated Part-day Preschool

REASON FOR CARE - SECONDARY PARENT not applicable

Working (my work zip code: _____) Attending School/Training (my school zip code: _____)

Looking for Work Medically Incapacitated Part-day Preschool

MONTHLY INCOME - PRIMARY PARENT

Total Monthly Wage \$ _____ <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	Child Support	Spousal Support	Cash Aid or Foster Payment	State Disability Insurance (SDI)	Supplemental Security Income (SSI)	Other Income Type: _____
Hours & Wage Hours per week _____ \$ per hour _____						

MONTHLY INCOME - SECONDARY PARENT not applicable

Total Monthly Wage \$ _____ <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	Child Support	Spousal Support	Cash Aid or Foster Payment	State Disability Insurance (SDI)	Supplemental Security Income (SSI)	Other Income Type: _____
Hours & Wage Hours per week _____ \$ per hour _____						

ELIGIBILITY ASSESSMENT

Are you currently receiving child care/preschool assistance for your child(ren)? Yes No
If yes, name of program: _____

Have you received Cash Aid (Welfare/TANF/AFDC) within the last 2 years? Yes No
If yes, date last received: _____

Are you currently participating in CalWORKs? Yes No

Centralized Eligibility List (CEL) Application

For Subsidized Child Care or Preschool in Santa Clara County

CHILD 1

Name:	School:	School District:
Date of birth:	Special Needs? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes,</i> <input type="checkbox"/> IEP <input type="checkbox"/> IFSP Please explain:	
Schedule of Care: <input type="checkbox"/> (F/T) Full time <input type="checkbox"/> (P/T) Part time <input type="checkbox"/> Evening <input type="checkbox"/> Weekend <input type="checkbox"/> Variable <input type="checkbox"/> Overnight		
Preferred Child Care Provider:		Preferred Program:
Preferred type of child care setting/arrangement: <input type="checkbox"/> Center <input type="checkbox"/> Licensed Family Home <input type="checkbox"/> Relative/Friend		
Currently Enrolled? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, what program:</i>		Reason for re-applying:

CHILD 2

Name:	School:	School District:
Date of birth:	Special Needs? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes,</i> <input type="checkbox"/> IEP <input type="checkbox"/> IFSP Please explain:	
Schedule of Care: <input type="checkbox"/> (F/T) Full time <input type="checkbox"/> (P/T) Part time <input type="checkbox"/> Evening <input type="checkbox"/> Weekend <input type="checkbox"/> Variable <input type="checkbox"/> Overnight		
Preferred Child Care Provider:		Preferred Program:
Preferred type of child care setting/arrangement: <input type="checkbox"/> Center <input type="checkbox"/> Licensed Family Home <input type="checkbox"/> Relative/Friend		
Currently Enrolled? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, what program:</i>		Reason for re-applying:

CHILD 3

Name:	School:	School District:
Date of birth:	Special Needs? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes,</i> <input type="checkbox"/> IEP <input type="checkbox"/> IFSP Please explain:	
Schedule of Care: <input type="checkbox"/> (F/T) Full time <input type="checkbox"/> (P/T) Part time <input type="checkbox"/> Evening <input type="checkbox"/> Weekend <input type="checkbox"/> Variable <input type="checkbox"/> Overnight		
Preferred Child Care Provider:		Preferred Program:
Preferred type of child care setting/arrangement: <input type="checkbox"/> Center <input type="checkbox"/> Licensed Family Home <input type="checkbox"/> Relative/Friend		
Currently Enrolled? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, what program:</i>		Reason for re-applying:

CHILD 4

Name:	School:	School District:
Date of birth:	Special Needs? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes,</i> <input type="checkbox"/> IEP <input type="checkbox"/> IFSP Please explain:	
Schedule of Care: <input type="checkbox"/> (F/T) Full time <input type="checkbox"/> (P/T) Part time <input type="checkbox"/> Evening <input type="checkbox"/> Weekend <input type="checkbox"/> Variable <input type="checkbox"/> Overnight		
Preferred Child Care Provider:		Preferred Program:
Preferred type of child care setting/arrangement: <input type="checkbox"/> Center <input type="checkbox"/> Licensed Family Home <input type="checkbox"/> Relative/Friend		
Currently Enrolled? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, what program:</i>		Reason for re-applying:

LIST CHILDREN THAT DO NOT NEED CARE

Name:	Date of birth:	If already enrolled, program:
Name:	Date of birth:	If already enrolled, program:
Name:	Date of birth:	If already enrolled, program:

APPLICATION CONSENT

By signing this application you acknowledge and grant permission for your application to be shared among participating agencies.

- I declare that the above information is complete and true to the best of my knowledge.
- I understand my eligibility is based upon information given here and that documentation will be required prior to enrollment.
- In order to remain active on the CEL, I must take immediate action to inform 4Cs of any changes to my address, phone number or income.
- This application is valid for 3 months, however I understand that if I do not update this application within 3 months, my name will be removed from the list.

Signature: _____ Date: _____

 **Questions? Call (877) 235-0095**