



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 _____

Please Print

PRIMARY PARENT

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

Date: _____ **Primary Parent Name:** _____ **Date of birth:** _____

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

City: _____ **State:** _____ **Zip Code:** _____

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

Email: _____ **Language:** _____ **Ethnicity:** _____

Family Size (include parents & children): _____ **Preferred zip codes:**(1) _____ (2) _____ (3) _____ (4) _____ (5) _____

SECONDARY PARENT not living in the home

Secondary Parent Name: _____

Date of birth: _____ **Cell:** () _____ **Work:** () _____

Email: _____ **Language:** _____ **Ethnicity:** _____

FAMILY INFORMATION

Characteristics (check all that apply): Child Protective Services Teen Parent Seasonal Migrant Worker 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 Student? Yes No *If yes, name of school:* _____ High School College University

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 (3 hours)

SECONDARY PARENT not living in the home

- Working (my work zip code: _____)
- Attending School/Training (my school zip code: _____)
- Looking for Work
- Medically Incapacitated
- Part-day Preschool (3 hours)

MONTHLY INCOME: Primary Parent

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

MONTHLY INCOME: Secondary Parent not living in the home

Total Monthly Wage \$ _____	Child Support	Cash Aid or Foster Payment	State Disability Insurance (SDI)	Supplemental Security Income (SSI)	Other Income Type: _____
<input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly					
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, provide your Case Number:* _____

Are you currently participating in CalWORKs? Yes No

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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 Center/Preschool:		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 Center/Preschool:		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 Center/Preschool:		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 Center/Preschool:		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:
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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**