



## Child Eligibility Application

### Child Information

- ❖ Child's Legal Name: \_\_\_\_\_  
(Last) (Middle) (First)
- ❖ Date of Birth: \_\_\_\_\_ (Please attach documentation)
- ❖ Gender:  Male  Female ❖ Ethnicity: \_\_\_\_\_
- ❖ Primary Language: \_\_\_\_\_ ❖ Secondary Language: \_\_\_\_\_
- ❖ Street Address (including apartment #): \_\_\_\_\_  
City: \_\_\_\_\_ State: California Zip Code: \_\_\_\_\_
- ❖ Mailing Address (if different than above): \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
- ❖ Health Insurance: (Please attach a copy)  Not insured  MediCal  Healthy Families: \_\_\_\_\_  
 Indian Health Benefits  Private Insurance: \_\_\_\_\_
- ❖ Physician Name: \_\_\_\_\_
- ❖ Date of Last Physical Exam: \_\_\_\_\_ (Please attach Physical Exam)
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- ❖ Dental Insurance: (Please attach a copy)  Not insured  MediCal  Healthy Families: \_\_\_\_\_  
 Indian Health Benefits  Private Insurance: \_\_\_\_\_
- ❖ Dentist Name: \_\_\_\_\_
- ❖ Date of Last Dental Exam: \_\_\_\_\_ (Please attach Dental Exam)
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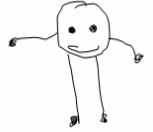
❖ **Diagnosed Medical Issues** (Please indicate any diagnosed medical or biological issues currently affecting your child.)

- Asthma  Diabetes  Heart condition  
 Eczema  Visual impairment  Food allergy: \_\_\_\_\_  
 Seizure disorder  Traumatic brain injury  Bee Sting allergy  
 Hearing impairment  Other: \_\_\_\_\_

Does your child require daily medication for diagnosed medical issues:  Yes  No

❖ **Diagnosed Disabilities** (Please attach documentation) **Date of last IEP/IFSP:** \_\_\_\_\_

- Autism  Emotional/Behavioral  Speech Delay  
 Orthopedic impairment  Developmental Delay  Other: \_\_\_\_\_

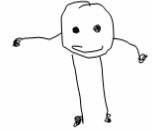


**Parent / Guardian Information** (The person signing the application should complete this section.)

- ❖ Parent/Guardian's Name: \_\_\_\_\_  
(Last) (Middle) (First)
- ❖ Date of Birth: \_\_\_\_\_ ❖ Gender:  Male  Female ❖ Ethnicity: \_\_\_\_\_
- ❖ Relationship to child: \_\_\_\_\_ ❖ Pregnant:  Yes  No Due Date: \_\_\_\_\_
- ❖ Telephone: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
(Home) (Work) (Cell)
- ❖ Primary Language: \_\_\_\_\_ ❖ Secondary Language: \_\_\_\_\_
- ❖ Are you currently working:  Part Time  Full Time  Seasonal  Unemployed
- ❖ Are you currently enrolled in school:  Yes  No ❖ Name of School: \_\_\_\_\_
- ❖ Source of Income (Please check all that apply and attach documentation):  
 Wages  TANF/AFDC  CalWorks/CaLearn  Food Stamps  Social Security  
 Unemployment  Child Support  Alimony/Spousal Support  Disability  Foster Subsidy
- ❖ Are you paid:  Weekly  Monthly  Twice Monthly  Every 2 weeks  Other: \_\_\_\_\_
- ❖ Highest Grade Completed: \_\_\_\_\_ ❖ Degree:  AA  BA  Masters  Doctorate

**Other Parent / Guardian Information**

- ❖ Parent/Guardian's Name: \_\_\_\_\_  
(First) (Middle) (Last)
- ❖ Date of Birth: \_\_\_\_\_ ❖ Gender:  Male  Female ❖ Ethnicity: \_\_\_\_\_
- ❖ Relationship to child: \_\_\_\_\_ ❖ Pregnant:  Yes  No Due Date: \_\_\_\_\_
- ❖ Telephone: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
(Home) (Work) (Cell)
- ❖ Primary Language: \_\_\_\_\_ ❖ Secondary Language: \_\_\_\_\_
- ❖ Are you currently working:  Part Time  Full Time  Seasonal  Unemployed
- ❖ Are you currently enrolled in school:  Yes  No ❖ Name of School: \_\_\_\_\_
- ❖ Source of Income (Please check all that apply and attach documentation):  
 Wages  TANF/AFDC  CalWorks/CaLearn  Food Stamps  Social Security  
 Unemployment  Child Support  Alimony/Spousal Support  Disability  Foster Subsidy
- ❖ Are you paid:  Weekly  Monthly  Twice Monthly  Every 2 weeks  Other: \_\_\_\_\_
- ❖ Highest Grade Completed: \_\_\_\_\_ ❖ Degree:  AA  BA  Masters  Doctorate
- ❖ Living in the Home:  Yes  No



## Family Status

- Two Parent Family    Single Parent Family    Single Parent Family with Partner    Foster Family
- ❖ Number of Adults in Family: \_\_\_\_\_ ❖ Number of Children in the Family: \_\_\_\_\_
- ❖ List full names and birthdates of all children in the family:

Name (First, Middle, Last)	Date of Birth	Gender
1) _____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
2) _____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
3) _____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
4) _____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
5) _____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female

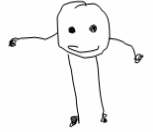
## Family Circumstances

- ❖ Has your family experienced any of the following in the past 12 months:
- |   |   |
|---|---|
| <input type="checkbox"/> Child abuse or neglect               | <input type="checkbox"/> Death in the family                      |
| <input type="checkbox"/> Divorce                              | <input type="checkbox"/> Domestic violence                        |
| <input type="checkbox"/> Drug or alcohol abuse                | <input type="checkbox"/> Parent or guardian is incarcerated       |
| <input type="checkbox"/> Public Health Nurse Support Received | <input type="checkbox"/> Counseling Services Received             |
| <input type="checkbox"/> Parent or guardian is disabled       | <input type="checkbox"/> Military deployment                      |
| <input type="checkbox"/> Open CPS Case                        | <input type="checkbox"/> Family Resource Center Services Received |
| <input type="checkbox"/> Restraining Order                    | <input type="checkbox"/> Other: _____                             |
- ❖ Does your family receive WIC:  Yes  No
- ❖ Please add any other concerns you have for your child and/or your family:

\_\_\_\_\_

\_\_\_\_\_

- ❖ What language do you prefer to communicate in should we have questions about the application?
- ❖ Spoken:  English    Spanish   ❖ Written:  English    Spanish



## Residence Information

- ❖ Does your family:  Own/Rent a Home  Temporarily Share a Home with Other People
- Live in a Hotel/Motel  Live in a Shelter
- Lack Regular Nighttime Housing  Live in a Car, Park or Other Public Place

## Childcare Needs

- ❖ Does your child need full day childcare:  Yes  No
- ❖ Does your child need full year childcare:  Yes  No

## Transportation

- ❖ How will your child get to and from school everyday:  Car  Walk  Carpool  
 Public Transportation  Other: \_\_\_\_\_
- ❖ I need transportation resources:  Yes  No

## PCAC Employment

- ❖ Are you or an immediate family member currently employed by PCAC:  Yes  No
- ❖ Relationship to child: \_\_\_\_\_

## Recruitment Tracking

- ❖ How did you hear about our program:  Event Name of Event: \_\_\_\_\_
- Another Agency Name of Agency: \_\_\_\_\_
- Sierra College TV Ad  Someone Came to My Door  Flyer  Banner
- Past or Present Parent (Word of Mouth)  Other: \_\_\_\_\_

**Please note:** You may be required to provide additional documents from your health care provider(s) and/or your special education provider(s) prior to your child attending the program. In addition, a special written plan may need to be agreed upon prior to your child attending the program. All submitted information will be kept confidential.

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I certify the information I have provided is accurate to the best of my knowledge. I understand I must provide all required documentation in order for my application to be processed. I understand that completion of this application does not guarantee enrollment.

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

\_\_\_\_\_  
Date Signed