



Fill out and submit this application to the **Marin Child Care Council's office**
 1600 Los Gamos Dr. Suite 365 - San Rafael, CA 94903 - Fax: 415 472 2805

Application for the Marin County Central Eligibility List

The Central Eligibility List (CEL) is a list of families in Marin County requesting financial assistance for childcare. This list will be used by various programs and agencies in Marin County that offer low- or no-cost subsidy programs to eligible families. These programs include programs funded by the California Department of Education (CDSS) and the Head Start program in Marin.

Please note that the Eligibility List (CEL) does not guarantee care services. You will be contacted by a Marin subsidy agency with access to CEL when your application is considered for an open position. Unfortunately, we do not have an estimated waiting time.

Information of the requesting parent

Parent (A) Name: _____ **Date of Birth:** _____ **Gender:** M F

Email _____ **Phone Number:** _____

Physical address: _____

Mailing address, if different from above: _____

Parent (B) Name: _____ **Date of Birth:** _____ **Gender:** M F

Email _____ **Phone Number:** _____

Do both parents live in the home? Yes No If no, do you have a custody order agreement? Yes No

Need for care services

Please check all options that apply to your family's needs for each parent/caretaker.

	Working	In School / Training Program	Medically Incapacitated	Job Search	Homeless / Seeking Permanent Housing
Parent A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If you have an active case with CFS	Worker name:		Phone number		
	Worker Email:				
If you have an active case of CFS, please include a referral letter with the application.					

Employment information (only if you selected that you are currently employed).

	Parent A	Parent B
Employer name		
Employer's phone number		
Postal code/city where you work		
Payment frequency	Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly <input type="checkbox"/> Hour <input type="checkbox"/>	Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly <input type="checkbox"/> Hour <input type="checkbox"/>
Amount	\$	\$
Maximum hours worked per week		

Does the parent have more than one employer? Complete the following information and select the second employer:

Parent A Parent B

Employer name		Employer's phone number	
Zip code/city where you work			
Payment frequency	Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly <input type="checkbox"/> Hour <input type="checkbox"/>	Amount: \$ _____	Max. hours worked per week: _____

If the parent is a student, please complete the following information:

Which parent is a student? Parent A <input type="checkbox"/> Parent B <input type="checkbox"/>	
Name of the school	
Zip code/city where the school is located	
Maximum hours required per week	Estimated graduation date
Educational goal	

Additional family income information (please indicate gross amount of applicable income).

<input type="checkbox"/> Cash Aid	Family:	\$ _____	Child / Children only	\$ _____
<input type="checkbox"/> SSA/SSI/SSP	Parent A <input type="checkbox"/> Parent B <input type="checkbox"/>	\$ _____	Children <input type="checkbox"/>	\$ _____

Child Support

Do you receive Child support, or do you pay it?	Paid <input type="checkbox"/> Received <input type="checkbox"/>	Amount	\$ _____
Payment frequency	Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly <input type="checkbox"/> Hour <input type="checkbox"/>		

If either parent pays support for other child(ren) outside the family, indicate the amount and how often you make your payments.

Are you currently receiving any of these services for yourself, your child(ren), or both? If so, select all that apply to your family.

Medi-Cal <input type="checkbox"/>	Cal- Fresh (food stamps) <input type="checkbox"/>	WIC <input type="checkbox"/>	California Food Assistance Program <input type="checkbox"/>
Head Start <input type="checkbox"/>	Early Head Start <input type="checkbox"/>	Federal Food Distribution Program on Indian Reservations <input type="checkbox"/>	
Have you received financial assistance in California (CalWORKs / Welfare)?			Yes <input type="checkbox"/> No <input type="checkbox"/> County _____
Date of your last payment		Family: <input type="checkbox"/>	Child / Children only <input type="checkbox"/>

Child's information

Please include all children under 18, or under 21 if they have special needs (this information is used to determine the total family size). If you are pregnant, you must wait until your child is born to add them to the family application.

Your child's name:			
Birthdate		Gender	M <input type="checkbox"/> F <input type="checkbox"/>
Choose if your child has a special education service plan	IEP <input type="checkbox"/>	IFSP <input type="checkbox"/>	<input type="checkbox"/>
If your child does not need care, please indicate here and continue with the information for the next child. <input type="checkbox"/>			
Does your child attend school (TK-12)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Name of the school _____	
Choose the type of care you need	Full time <input type="checkbox"/>	Part-time <input type="checkbox"/>	Preschool <input type="checkbox"/>
	Before/after school <input type="checkbox"/>		In the evenings/weekends <input type="checkbox"/>
City or zip code where you need care services _____			
Your child's name:			
Birthdate		Gender	M <input type="checkbox"/> F <input type="checkbox"/>
Choose if your child has a special education service plan	IEP <input type="checkbox"/>	IFSP <input type="checkbox"/>	<input type="checkbox"/>

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City or zip code where you need care services				

Signature of parent who completed this application: _____ date: _____

FOR OFFICE USE ONLY			
CEL application received date			
Date entered		By whom (staff initials)	