



Application (2 m - 5 years)

Please Note: *Priority* goes to low-income CSU students

Date of Application _____ Number in Family _____

Application for admission Fall / Spring of _____ Anticipated graduation date: _____

Parent (guardian) Status CSUC Student Butte College Community

CHILD'S NAME _____ **DATE OF BIRTH** _____ Sex _____

PARENT #1 _____ PARENT #2 _____

College/Employment _____ Living in home with child? YES NO
 _____ College/Employment _____

Siblings Living at Home:

Name _____	M F	Date of Birth _____
Name _____	M F	Date of Birth _____
Name _____	M F	Date of Birth _____
Name _____	M F	Date of Birth _____

Household GROSS monthly income (for both live in parents) including wages from:

Employment, Child/Spousal Support, Unemployment, Worker's Comp.... \$ _____ **per month**
 (Proof of income will be required prior to enrollment)

Do you receive WIC? YES NO

Do you receive Public Assistance, Cal Works or TANF? YES NO \$ _____ per month

Do you receive (SNAP) Cal Fresh? YES NO Cal Fresh ID# _____

Do you receive Financial Aid, Grants, Scholarships (EXCLUDING LOANS)? YES NO

Are you or your child covered by Medi- Cal? YES NO

Do you receive the Pell Grant? YES NO (if unsure, please contact the Financial Aid & Scholarship Office at 530-898-6451 or go to <http://www.csuchico.edu/fa/index/shtml> for more information)

What is your child's primary home language? _____

Does your child have exceptional needs and/or have an IFSP, IEP? YES NO

Explain _____

Does your child have any allergies or dietary restrictions? YES NO

Explain: _____

Please Note:

* The ASCDL does not offer drop in care and requires a 2 day / 10 hour minimum to enroll. *

Share any additional information relevant to enrolling your child-

PARENT SIGNATURE _____ PHONE# _____

Address _____ EMAIL _____



EARLY HEAD START-CHILD CARE PARTNERSHIP (EHS-CCP) APPLICATION

Please attach the following: • Income -12 months (1040, W-2s, TANF voucher, etc.) • Proof of Birth • Immunizations

CHILD APPLICANT INFORMATION					
Child First and Last Name:			Family Member of Head Start Staff? <input type="checkbox"/> No <input type="checkbox"/> Yes: Name:		
DOB:	Gender: M F	Child Language:	Primary Language at Home:		
Child Race (check all that apply): Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi-racial/Bi-racial (List): _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unspecified					
Living Address, City, State, Zip:					
Work Phone:		Cell Phone:	Shared housing/Homeless: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Primary Health Coverage: <input type="checkbox"/> None <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Other/Private (list):					
Does your child have a disability or special need? <input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> Suspected <input type="checkbox"/> Diagnosed					
Does your child have any medical concerns? <input type="checkbox"/> No <input type="checkbox"/> Yes (list):					
Doctor Name/Address/Ph:					
Dentist Name/Address/Ph:					
Referred by Child Welfare Agency: <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you receive TANF of SSI? <input type="checkbox"/> Yes <input type="checkbox"/> No	Active Duty Military? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you receive WIC? <input type="checkbox"/> Yes <input type="checkbox"/> No		SNAP (CalFresh)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Parent/Guardian is a U.S Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Parental Status: <input type="checkbox"/> Single Parent <input type="checkbox"/> Two					
LIST ALL PERSONS LIVING IN THE HOUSEHOLD, SUPPORTED BY THE INCOME OF THE PARENTS/GUARDIANS OF THE CHILD ENROLLED AND RELATED TO THE PARENTS BY BLOOD, MARRIAGE OR ADOPTION:					
1) PRIMARY ADULT FIRST/LAST NAME		DOB	RACE	HISPANIC	GENDER
				<input type="checkbox"/> Yes <input type="checkbox"/> No	M F
RELATIONSHIP TO CHILD <small>(Father, mother, grandparent, foster parent, etc.)</small>		EMPLOYMENT STATUS <small>(Full/Part-time; Unemployed, Seasonal; Training etc.)</small>		HIGHEST GRADE COMPLETED <small>(HS Diploma; GED; AA/BA; training certificate; etc.)</small>	
2) SECONDARY ADULT FIRST/LAST NAME		DOB	RACE	HISPANIC	GENDER
				<input type="checkbox"/> Yes <input type="checkbox"/> No	M F
RELATIONSHIP TO CHILD <small>(Father, mother, grandparent, foster parent, etc.)</small>		EMPLOYMENT STATUS <small>(Full/Part-time; Unemployed, Seasonal; Training etc.)</small>		HIGHEST GRADE COMPLETED <small>(HS Diploma; GED; AA/BA; training certificate; etc.)</small>	
3) OTHER ADULT FIRST/LAST NAME		DOB	RACE	HISPANIC	GENDER
				<input type="checkbox"/> Yes <input type="checkbox"/> No	M F
RELATIONSHIP TO CHILD <small>(Father, mother, grandparent, foster parent, etc.)</small>		EMPLOYMENT STATUS <small>(Full/Part-time; Unemployed, Seasonal; Training etc.)</small>		HIGHEST GRADE COMPLETED <small>(HS Diploma; GED; AA/BA; training certificate; etc.)</small>	
OTHER CHILDREN IN HOME					
FIRST AND LAST NAME	DOB	RACE	GENDER	RELATIONSHIP TO PRIMARY ADULT	
			M F		
			M F		
			M F		
			M F		

I consent for exchange of eligibility information if needed (i.e. 3rd party income verification).

I certify under penalty of perjury that the information in this enrollment packet is true and complete to the best of my knowledge. If any part is false or omitted, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency.

PARENT/GUARDIAN SIGNATURE

DATE