

Infant and Toddler Application (ages 2 mos. to 34 mos.) AS CHILD DEVELOPMENT LAB APPLICATION

California State University, Chico  
(Fax to 530/898-5639)

Priority goes to low-income CSU students then income qualified families.

Date of Application \_\_\_\_\_

Number in Family \_\_\_\_\_

Application for Admission for Fall of \_\_\_\_\_ or Spring of \_\_\_\_\_

Parent (guardian) Status:  CSU Chico Student  CSU Staff/Faculty  Community

Do you receive Pell Grant? \_\_\_\_\_ Yes \_\_\_\_\_ No (If you are not sure, you can contact the Financial Aid & Scholarship Office at 530-898-6451 or go to <http://www.csuchico.edu/fa/index/shtml> for more information)

Calculate your Household's Gross Monthly Income (for both live-in parents) including:

Wages, Child/Spousal Support, Unemployment, Worker's Compensation; Others: (Proof of income will be required prior to enrollment) \$ \_\_\_\_\_

Public Assistant, CalWorks, TANF (excluding CalFresh):  Yes  No (If yes, please attach a copy plus your Financial Aid) \$ \_\_\_\_\_

Financial Aid, Grant, Scholarship (excluding loans): one Year (Y) or Semester (S): (\_\_\_\_) \$ \_\_\_\_\_

Anticipated Graduation Date \_\_\_\_\_

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_

Parent 1: _____  Occupation / Institution _____	Parent 2: _____  Living in home with child? _____  Occupation / Institution _____
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Siblings Living At Home:	<u>Name</u>	<u>Sex</u>	<u>Birthdate</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe any special needs your child may have or share any additional information and/or comments relevant to enrolling your child in this program.

\_\_\_\_\_  
\_\_\_\_\_

PARENT'S SIGNATURE \_\_\_\_\_ PHONE# \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

(Should you change your Phone Number, Email or Income, please notify us by calling 530/898-5865)

ADDRESS \_\_\_\_\_

\_\_\_\_\_



# 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 or 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 (Father, mother, grandmother, foster parent, etc.)	EMPLOYMENT STATUS (Full/Part-time; Unemployed, Seasonal; Training etc.)		HIGHEST GRADE COMPLETED (HS Diploma; GED; AA/BA; training certificate; etc.)	
2) SECONDARY ADULT FIRST/LAST NAME	DOB	RACE	HISPANIC	GENDER
			<input type="checkbox"/> Yes <input type="checkbox"/> No	M F
RELATIONSHIP TO CHILD (Father, mother, grandmother, foster parent, etc.)	EMPLOYMENT STATUS (Full/Part-time; Unemployed, Seasonal; Training etc.)		HIGHEST GRADE COMPLETED (HS Diploma; GED; AA/BA; training certificate; etc.)	
3) OTHER ADULT FIRST/LAST NAME	DOB	RACE	HISPANIC	GENDER
			<input type="checkbox"/> Yes <input type="checkbox"/> No	M F
RELATIONSHIP TO CHILD (Father, mother, grandmother, foster parent, etc.)	EMPLOYMENT STATUS (Full/Part-time; Unemployed, Seasonal; Training etc.)		HIGHEST GRADE COMPLETED (HS Diploma; GED; AA/BA; training certificate; etc.)	

### OTHER CHILDREN IN HOME

FIRST AND LAST NAME	DOB	RACE	GENDER	RELATIONSHIP TO PRIMARY ADULT
			M F	
			M F	
			M F	
			M F	
			M F	

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 \_\_\_\_\_