Application can be **Mailed, Faxed or Emailed.**

Mail: 4C Council R&R Dept.
150 River Oaks Pkwy. #F-1
San Jose, CA 95134

Fax: (408) 487-0762
Email: celinfo@4c.org

Contact information:
Website: www.4c.org
Phone: (408) 487-0749

4C Centralized Eligibility List (CEL) Application

For Subsidized Child Care or Preschool in Santa Clara County

OFFICE USE ONLY: ☐ Intake ☐ Update • ☐ R&R ☐ CalWORKS • ☐ FCSAD ☐ CCSAD • Rank ____ ID_____

Please Print

PRIMARY PARENT

Check all that apply: ☐ Parent ☐ Foster Parent* ☐ Legal Guardian* ☐ Child Protective Services*

***Attach Proof of Foster Placement, Guardianship or Child Protective Services**

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):	**List preferred zip codes for child care:**	

REASON FOR CARE

☐ Working (my work zip code: _____)
☐ Attending School/Training(my school zip code: _____)
☐ Looking for Work
☐ Medically Incapacitated

GROSS MONTHLY INCOME (BEFORE TAXES)

Hours & Wage

Hours per week _____ $ per hour_____ ☐Monthly ☐Bi-weekly ☐Weekly

Total Monthly Wage_____

Child Support	Cash Aid or Foster Payment	State Disability Insurance (SDI)	Other Income Type:_____

SECONDARY PARENT ☐ check if not living in the home

Secondary Parent Name:

Date of birth:	**Cell: ( )**	**Work: ( )**
Email:	**Language:**	**Ethnicity:**

REASON FOR CARE

☐ Working (my work zip code: _____)
☐ Attending School/Training(my school zip code:_____)
☐ Looking for Work
☐ Medically Incapacitated

GROSS MONTHLY INCOME (BEFORE TAXES)

Hours & Wage

Hours per week _____ $ per hour_____ ☐Monthly ☐Bi-weekly ☐Weekly

Total Monthly Wage_____

Child Support	Cash Aid or Foster Payment	State Disability Insurance (SDI)	Other Income Type:_____

FAMILY INFORMATION

Marital Status (check one): ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Housing (check all that apply): ☐ Currently homeless ☐ Living in a shelter

ELIGIBILITY ASSESSMENT

As a parent, are you currently receiving child care/preschool assistance for your child(ren)? ☐ Yes ☐ No ***If yes***, name of Program: _____

As a parent, have you received Cash Aid (Welfare/TANF/AFDC) within the last 2 years? ☐ Yes ☐ No ***If yes***, provide your Case Number: _____

As a parent, are you currently participating in CalWORKs? ☐ Yes ☐ No

- over, please -

4C Centralized Eligibility List (CEL) Application

For Subsidized Child Care or Preschool in Santa Clara County

CHILD 1

Name:	**School:**	**School District:**
Date of birth:	**Please circle: Male Female**	☐ **Check if schedule of care (days/hrs) may vary**
Please circle days of care needed: S M T W Th F S	**Indicate hours of care: _____am/pm TO _____am/pm**	
Special Needs? ☐ Yes ☐ No ***If yes,*** ☐ IEP ☐ IFSP	**Please explain:**	
Preferred type of child care: ☐ Center ☐ Licensed Family Home ☐ Relative/Friend ☐ No Preference		

CHILD 2

Name:	**School:**	**School District:**
Date of birth:	**Please circle: Male Female**	☐ **Check if schedule of care (days/hrs) may vary**
Please circle days of care needed: S M T W Th F S	**Indicate hours of care: _____am/pm TO _____am/pm**	
Special Needs? ☐ Yes ☐ No ***If yes,*** ☐ IEP ☐ IFSP	**Please explain:**	
Preferred type of child care: ☐ Center ☐ Licensed Family Home ☐ Relative/Friend ☐ No Preference		

CHILD 3

Name:	**School:**	**School District:**
Date of birth:	**Please circle: Male Female**	☐ **Check if schedule of care (days/hrs) may vary**
Please circle days of care needed: S M T W Th F S	**Indicate hours of care: _____am/pm TO _____am/pm**	
Special Needs? ☐ Yes ☐ No ***If yes,*** ☐ IEP ☐ IFSP	**Please explain:**	
Preferred type of child care: ☐ Center ☐ Licensed Family Home ☐ Relative/Friend ☐ No Preference		

CHILD 4

Name:	**School:**	**School District:**
Date of birth:	**Please circle: Male Female**	☐ **Check if schedule of care (days/hrs) may vary**
Please circle days of care needed: S M T W Th F S	**Indicate hours of care: _____am/pm TO _____am/pm**	
Special Needs? ☐ Yes ☐ No ***If yes,*** ☐ IEP ☐ IFSP	**Please explain:**	
Preferred type of child care: ☐ Center ☐ Licensed Family Home ☐ Relative/Friend ☐ No Preference		

For proof of Family Size, list children living in the home that DO NOT need care

Name:	**Date of birth:**	**If already enrolled, program:**
Name:	**Date of birth:**	**If already enrolled, program:**
Name:	**Date of birth:**	**If already enrolled, program:**

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 (408) 487-0749**

For Office Use

Initial Intake Completed by: _____ Data Entry Completed by: _____ Date: