



## ENROLLMENT APPLICATION

### Application Instructions:

Complete the following forms: (attached)

- Include names and date of birth (DOB) of all your children in the household.
- Financial Report with complete employment information (if applicable).
- Provide an original most recent paycheck stub(s) for a period of one month (copies will be made).

Provide a driver's license or other official ID with your photo on it (copies will be made).

Upon completion and review of the application and supporting documents, your child will be eligible for care at the location you have requested (subject to space availability).

### Eligibility Requirements:

Parent(s) must provide documentation of full-time work, full-time school or training program enrollment, a combination of work and school, medically incapacitated, homelessness, or looking for work.

Provide original paycheck stubs and/or documentation of registration for school or training program.

### Select a location:


#### **West Branch**

1548 Chestnut Ave. Long Beach, CA 90813      (562) 591-0509

#### **East Branch**

3965 Bellflower Bl., Long Beach, CA 90808      (562) 421-1488

### Where did you hear about LBDN?

- [ ] Magazine/Newspaper (please specify) \_\_\_\_\_
- [ ] Phone Book (please specify) \_\_\_\_\_
- [ ] Friend/Family (please specify) \_\_\_\_\_
- [ ] Driving by LBDN (please specify location) \_\_\_\_\_
- [ ] Other (please specify) \_\_\_\_\_

**Application**

Name of Parent or Guardian #1: _____	
Home Address: _____	
City, State & Zip code: _____	
Home Phone: _____	Work Phone: _____
Mobile Phone: _____	Email: _____
Name of Parent or Guardian #2: _____	
Address (if different from above): _____	
City, State & Zip code: _____	
Home Phone: _____	Work Phone: _____
Mobile Phone: _____	Email: _____

Single Parent Household: \_\_\_\_\_ Two Parent Household: \_\_\_\_\_

Name(s) of other adult(s) in the household: \_\_\_\_\_

Number of children in household: \_\_\_\_\_

**Children Living at Home:**

First and Last Name	Birth Date	Child needs Care (check if "YES")	Date Care is Needed	Foster Child (check if "YES")	Foster Amount (monthly)
1.	/ /		/ /		\$
2.	/ /		/ /		\$
3.	/ /		/ /		\$
4.	/ /		/ /		\$
5.	/ /		/ /		\$
6.	/ /		/ /		\$

(continued on next page)

**Tuition Payment Type:**

How will you be paying your child(ren)'s tuition?

- I will be paying the full tuition.
- I have payment through Children's Home Society or other agency.
- I am requesting State Funds.
- I am requesting assistance through LBDN's Stepping Stones to Success Scholarship Funds.

**Child(ren) with Special Needs (check if "YES"):**

	Limited English	Child Protective Services	Severely Handicapped	Does child have an IEP, IFSP, or receive services through Regional Center or School District?
Child # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



For official use only:

Subsequent Contacts

Admission interview date: \_\_\_\_\_ time: \_\_\_\_\_

One hour visit following:  Yes  No

**Financial Report**

**Employment Information:**

Parent/Guardian #1 Company/Employer: \_\_\_\_\_

Work/Training Institution Address: \_\_\_\_\_

City, State & Zip code: \_\_\_\_\_

Department/Position/Major: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Hours of work/training: \_\_\_\_\_ to \_\_\_\_\_ How often are you paid?  
[ ] weekly [ ] monthly  
[ ] every other week [ ] twice a month

Parent/Guardian #2 Company/Employer: \_\_\_\_\_

Work/Training Institution Address: \_\_\_\_\_

City, State & Zip code: \_\_\_\_\_

Department/Position/Major: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Hours of work/training: \_\_\_\_\_ to \_\_\_\_\_ How often are you paid?  
[ ] weekly [ ] monthly  
[ ] every other week [ ] twice a month

**Sources of Family Income:** (check all that apply including the amount)

- [ ] Work/Employment \$ \_\_\_\_\_ [ ] Sales/Commission/Tips \$ \_\_\_\_\_
- [ ] Child Support \$ \_\_\_\_\_ [ ] Alimony \$ \_\_\_\_\_
- [ ] CALWORKS \$ \_\_\_\_\_ [ ] State Disability \$ \_\_\_\_\_
- [ ] Unemployment Benefits \$ \_\_\_\_\_ [ ] Service Allotment \$ \_\_\_\_\_
- [ ] Social Security \$ \_\_\_\_\_ [ ] Workman's Compensation \$ \_\_\_\_\_
- [ ] Other \$ \_\_\_\_\_

**Attach a copy of your latest pay and other check stubs for a period of one month.**

**Please read and sign:**

- o A new financial report and an updated emergency information form are required every 6 months or whenever there is a change.
- o You are responsible for reporting any change in income, employment, or family status. Failure to do so may result in your child being discontinued.
- o Your child may be excluded from attendance at the Long Beach Day Nursery if you do not provide this information promptly upon request.

I hereby certify that all of the above information is true and correct.

\_\_\_\_\_  
Signature of parent/guardian Date

**Request for Subsidized Waiting List**

LBDN has limited funding to provide low-cost to free child care. You may meet guidelines for this funding. Please indicate your interest by completing this form. Enrollment is based on available funding.

Name of Parent or Guardian #1: _____		
Home #: _____	Work #: _____	Mobile #: _____
Name of Parent or Guardian #2: _____		
Home #: _____	Work #: _____	Mobile #: _____

**Need for Child Care (Please check all that apply for each parent and other adults in household):**

	Parent/Guard. #1	Parent/Guard. #2	Other Adult #1	Other Adult #2
Working	[ ]	[ ]	[ ]	[ ]
In School/Training	[ ]	[ ]	[ ]	[ ]
Medically Incapacitated	[ ]	[ ]	[ ]	[ ]
Seeking Employment	[ ]	[ ]	[ ]	[ ]
Homeless	[ ]	[ ]	[ ]	[ ]

Name of Child: \_\_\_\_\_

[ ] Currently Enrolled      [ ] Not Enrolled

Name of Child: \_\_\_\_\_

[ ] Currently Enrolled      [ ] Not Enrolled



For official use only:

Rank: \_\_\_\_\_

Income: \_\_\_\_\_

Family size: \_\_\_\_\_

Child DOB: \_\_\_\_\_

**Los Angeles Centralized Eligibility List**  
**A Program of the County of Los Angeles Child Care Planning Committee**

**Registration Form**

**Introduction**

The County of Los Angeles Child Care Planning Committee (CCPC) has created the Los Angeles Centralized Eligibility List (LACEL) to help connect low-income families with child care and development subsidies as child care spaces and funding become available. By completing this form, you are registering on the LACEL. The information you provide on this form will help determine your eligibility for a child care subsidy. Registration on the LACEL allows a child care and development program to contact you if and when a subsidized child care space becomes available. At that time, the program staff will verify the information you provided on this form to make sure you are eligible before you are invited to enroll your child. All information is handled confidentially.

For more information on the LACEL, please contact the County of Los Angeles Office of Child Care at (213) 974-1664 or visit the web site at [www.lacountychildcare.org](http://www.lacountychildcare.org).

<b>COMPLETE BOTH SIDES OF FORM</b>		<b>Application Date:</b>	
<b>Parent/Guardian #1 Information</b>			
Last name:		First name:	
Street address:		City:	Zip Code:
Home phone:	Work/other phone:	Primary language:	
Name of employer/school:		Work/school zip code:	
Indicate if your household is a <input type="checkbox"/> Single parent family <input type="checkbox"/> Two parent family			
<b>Parent/Guardian #2 Information (Complete only if there is another parent/guardian residing in the same home.)</b>			
Last name:		First name:	
Name of employer/school:		Work/school zip code:	Work/other phone:
<b>Reason for Needing Child Care (Check all that apply.)</b>			
	<b>Parent/Guardian #1</b>	<b>Parent/Guardian #2</b>	
Working	<input type="checkbox"/>	<input type="checkbox"/>	
Attending School or Job Training	<input type="checkbox"/>	<input type="checkbox"/>	
Medically Incapacitated/Disabled	<input type="checkbox"/>	<input type="checkbox"/>	
Looking for Work	<input type="checkbox"/>	<input type="checkbox"/>	
Homeless/Seeking housing	<input type="checkbox"/>	<input type="checkbox"/>	
Migrant Worker	<input type="checkbox"/>	<input type="checkbox"/>	
Part-day educational preschool experience for child	<input type="checkbox"/>	<input type="checkbox"/>	
<b>CalWORKs Participation (Cash aid)</b>			
Are you currently receiving cash aid? <input type="checkbox"/> Yes <input type="checkbox"/> No	If <b>NO</b> , have you received cash aid within the last two years? <input type="checkbox"/> Yes <input type="checkbox"/> No	If <b>YES</b> , last date of cash aid payment: _____ / _____ / _____	

**Monthly Income and Sources** (Enter total dollars, before taxes and deductions, for each source of income for parents/guardians in the household.)

	Parent/Guardian #1	Parent/Guardian #2
Work/Employment	\$	\$
Child Support	\$	\$
Spousal Support	\$	\$
State Disability	\$	\$
Unemployment benefits	\$	\$
Sales/Work Commissions	\$	\$
Cash Aid (CalWORKs)	\$	\$
Worker's Compensation	\$	\$
Social Security	\$	\$
SSI/SSP	\$	\$
Other (explain):	\$	\$

**Children Living at Home** (All children under 18 who are members of the family. Attach an additional page, if needed.)

First and Last Name	Gender	Date of Birth	Check only if child care is needed.		
			Full-time	Part-time	Evenings /Weekends
1.	F M		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	F M		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	F M		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Foster Care Payments**

Are you currently receiving foster care payments for any of the children listed above? Check which child and write the monthly amount.  
 Child # 1 \$ \_\_\_\_\_ |  Child # 2 \$ \_\_\_\_\_ |  Child # 3 \$ \_\_\_\_\_

**Special Needs** (Check all that apply)

	Child # 1	Child # 2	Child # 3
Child Protective Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child has IFSP (Individual Family Service Plan) or IEP (Individual Education Plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child receives services through Regional Center or the local School District	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social emotional/behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ongoing health problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental delays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech/communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision or hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please explain):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Preferred Location or Program** (List below your preferred zip code location, if different from home or work. You may list the name of the program you prefer for your child.)

Child #1	Zip Code:	Name of Program/Agency:
Child #2	Zip Code:	Name of Program/Agency:
Child #3	Zip Code:	Name of Program/Agency:

**School Age Children** (Complete for school age children only.)

Child #1	Grade:	Name of School/School District:
Child #2	Grade:	Name of School/School District:
Child #3	Grade:	Name of School/School District: