

CALIFORNIA STATE PRESCHOOL/GENERAL CHILD CARE/HEAD START PROGRAM APPLICATION REQUIREMENTS CHECKLIST (INITIAL ENROLLMENT)

To verify and determine eligibility for subsidized childcare services, you must bring **copies** of the following documentation to your certification appointment:

ELIGIBILITY VERIFICATION – Documentation must be provided for **1** or more of these categories

- ☐ CPS or At-Risk Referral Letter
- ☐ Self-Declaration of Homelessness or Referral Letter
- ☐ Current Aid Recipient Verification (Example: Notice of Action or Verification of Benefits)
- ☐ Categorical Eligibility (Example: Notice of Action, Verification of Benefits, or application for: CalWORKs, Medi-Cal, Cal Fresh, the California Food Assistance Program, the California Special Supplemental Nutrition Program for Women, Infants, and Children, the federal Food Distribution Program on Indian Reservations, Head Start or Early Head Start)
- ☐ Income Verification
 - ☐ W-2 Forms, 1040 and Tax Forms
 - ☐ Income documentation from all sources (including any income received for guardianship, foster, or adoption)
 - Predictable Income: Gross Income for the month two proceeding certification
 - Unpredictable Income: Gross Income for the preceding 2-12 months
(Seasonal, agricultural, includes bonuses or commission provide past 12 consecutive months of income)

FAMILY SIZE VERIFICATION –At least **1** of the following documents must be provided for **ALL** children counted in the family size:

- ☐ Birth Certificate
- ☐ Verification of Benefits from the county welfare department
- ☐ Court orders and documents regarding child custody, guardianship, foster care, or adoption

RESIDENCY VERIFICATION – Proof that you live in the State of California

- ☐ Any type of evidence of your street address or post office box from the month or two proceeding certification

NEED – All adults must meet at least **1** need criteria. Documentation to establish need is as follows:

- ☐ Employment Verification
- ☐ Declaration of Self-Employment & Support Documentation
- ☐ Training Verification or Educational Program Verification & Class Schedule
- ☐ Request & Plan to Seek Employment
- ☐ Statement of Incapacity
- ☐ Request & Plan to Seek Permanent Housing
- ☐ CPS or At-Risk Referral Letter
- ☐ Homelessness Referral Letter

OTHER DOCUMENTATION – The following documents are also required:

- ☐ Family Information Form
- ☐ Emergency Card for each enrolled child
- ☐ Parent Notification: Requirement to Report Income Over 85% or 100% of SMI (if eligibility is income)
- ☐ Child's immunization record for each child being enrolled
- ☐ Child Information Form
- ☐ If applicable, court orders if they affect your childcare days/hours
- ☐ If applicable, child's Infant & Family Service Plan (IFSP) or Individual Education Plan (IEP)

NOTE: If your packet is not complete on your appointment date, we cannot accept it

IF YOU HAVE ANY QUESTIONS, PLEASE CALL YOUR FAMILY ELIGIBILITY SPECIALIST AT (209) 238-6300.

INCOME

Reminder: You must submit full, current and consecutive income for each adult/child counted in the family size. If any individual's income fluctuates due to commission, bonuses or seasonal work, you must submit the past twelve months gross income.

Countable Income Sources Countable income is income of individuals counted in the family size that shall be included when calculating the adjusted monthly income for purposes of determining income eligibility and family fees.	Non-Countable Income Sources Non-countable income is income of individuals counted in the family size that shall be excluded when calculating the adjusted monthly income for purposes of determining income eligibility and family fees.
- Gross wages, salary, advances, commissions, overtime, tips, bonuses, gambling or lottery winnings - Wages for migrant, agricultural, or seasonal work - CalWORKs cash aid - Gross income from self-employment less business expenses with the exception of wage draws - Disability or unemployment compensation - Worker's compensation - Spousal support and/or child support from the former spouse or absent parent, or (documented) financial assistance for housing costs, car payments paid as part of or in addition to spousal or child support - Survivor (i.e. SSA) and retirement benefits - Rent for room within the family's residence - Dividends, interest on bonds, income from estates or trusts, net rental income or royalties - Financial assistance received for the care of a child living with an adult who is not the child's biological or adoptive parent - Veteran's pension - Pension or annuities - Inheritance - Allowances for housing or automobiles provided as part of compensation - Insurance or court settlements for lost wages and/or punitive damages - Net proceeds from the sale of real property, stocks or inherited property - Other enterprise for gain	- Earnings of child under eighteen (18) years - Loans - Grants or scholarships to students for educational purposes - Federal Supplemental Assistance Program (CalFRESH/SNAP) or Women, Infants and Children (WIC) benefits or other food assistance - Earned Income Tax Credit or tax refund - Foster care grants, payment or clothing allowances for children placed through child welfare services - Relative Caregiver Funding Program - California Guaranteed Income Pilot Program - GI Bill entitlements, hardship or hazardous duty, hostile fire or immediate danger pay - Adoption assistance payments - Non-cash assistance or gifts - All income of any individual counted in the family size who is collecting federal Supplemental Security Income (SSI) or State Supplemental Program (SSP) benefits - Insurance or court settlements including pain and suffering and excluding lost wages and punitive damages - Reimbursements for work-required expenses that include uniforms, mileage, or per diem expenses for food and lodging - Business expenses for self-employed family members - When there is no cash value to the employee, the portion of medical and/or dental insurance documented as paid by the employer and included in gross pay - Disaster relief grants or payments, except any portion - AmeriCorps Volunteers In Service to America (VISTA) and Federal Emergency Management Agency (FEMA) stipends, room and board, and grants

Note: Verified child support payments paid by the parent whose child is receiving child development services may be subtracted from family's countable income

**FAMILY INFORMATION FORM
SCOE GO CENTER BASED SITES**

PLEASE PRINT CLEARLY

Single Parent/Guardian Household: ☐ Yes ☐ No - If "No" complete Parent/Guardian (B) information below

Parent/Guardian

(A) Name: _____

Birth Date: _____

Gender: ☐ Female ☐ Male

Address: _____

Phone #: _____

Email: _____

Race: ☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Caucasian
☐ Native Hawaiian or Other Pacific Islander

Language: _____

Ethnicity: ☐ Not Hispanic or Latino
☐ Hispanic or Latino

Relationship to Child: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced
☐ Widowed ☐ Formal Separation ☐ Informal Separation

Need for Services:

- ☐ No Need (Part Day CSPP)
☐ Actively Seeking Employment

Circle the days you will seek employment:

M T W TH F

- ☐ Employed / Self Employment
☐ School / Training
☐ Incapacitated
☐ Homeless
☐ CPS / At Risk

Parent/Guardian

(B) Name: _____

Birth Date: _____

Gender: ☐ Female ☐ Male

Address: _____

Phone #: _____

Email: _____

Race: ☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Caucasian
☐ Native Hawaiian or Other Pacific Islander

Language: _____

Ethnicity: ☐ Not Hispanic or Latino
☐ Hispanic or Latino

Relationship to Child: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced
☐ Widowed ☐ Formal Separation ☐ Informal Separation

Need for Services:

- ☐ No Need (Part Day CSPP)
☐ Actively Seeking Employment

Circle the days you will seek employment:

M T W TH F

- ☐ Employed / Self Employed
☐ School / Training
☐ Incapacitated
☐ Homeless
☐ CPS / At Risk

Other individual(s) in the home that will **not** be enrolled on the program and are counted in family size:

Attach documentation.

Name:

Relationship to Parent(s)/Guardian(s):

Birth Date:

Complete one column per child enrolling.

(Make additional copies as needed)

Child Name: _____
Birth Date: _____
Birth City & State: _____
Birth Country: _____

Gender: ☐ Female ☐ Male
Race: ☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Caucasian
☐ Native Hawaiian or Other Pacific Islander

Language: At home, does your child hear, understands, or speak a language other than English? ☐ Yes ☐ No

If Yes, which language: _____

Ethnicity: ☐ Not Hispanic or Latino
☐ Hispanic or Latino

Special Needs: ☐ Yes ☐ No
IFSP expiration date: _____
IEP expiration date: _____
If Yes, attach current IEP or IFSP

**Relationship to Parent/
Guardian:** _____

Childcare will be approved based on verified need.

**Specify the days and hours you are requesting
childcare with above classroom site. (Note: all travel
time needs to be requested for transportation)**

Days and hours requested:

Child Name: _____
Birth Date: _____
Birth City & State: _____
Birth Country: _____

Gender: ☐ Female ☐ Male
Race: ☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Caucasian
☐ Native Hawaiian or Other Pacific Islander

Language: At home, does your child hear, understands, or speak a language other than English? ☐ Yes ☐ No

If Yes, which language: _____

Ethnicity: ☐ Not Hispanic or Latino
☐ Hispanic or Latino

Special Needs: ☐ Yes ☐ No
IFSP expiration date: _____
IEP expiration date: _____
If Yes, attach current IEP or IFSP

**Relationship to Parent/
Guardian:** _____

Childcare will be approved based on verified need.

**Specify the days and hours you are requesting childcare
with above classroom site. (Note: all travel time needs to
be requested for transportation)**

Days and hours requested:

Parent/Guardian Signature _____ **Date:** _____

PARENT NOTIFICATION: REQUIREMENT TO REPORT INCOME OVER 85% THRESHOLD

Our records indicate that your family's basis for eligibility is income. The regulations require a family to report when their income exceeds the exit threshold. The income ceilings are based on family size and a family's adjusted gross income (Income before taxes). Effective July 1, 2025, the exit thresholds are as follows:

Family Size	Family Monthly Income	Family Yearly Income
1-2	\$6,860	\$82,326
3	\$7,785	\$93,418
4	\$9,020	\$108,237
5	\$10,463	\$125,555
6	\$11,906	\$142,873
7	\$12,177	\$146,120
8	\$12,447	\$149,367
9	\$12,718	\$152,615
10	\$12,988	\$155,862
11	\$13,259	\$159,109
12	\$13,530	\$162,356

My signature below acknowledges that I understand it is my responsibility to notify Stanislaus County Office of Education within 30 calendar days if, and when my adjusted **monthly** gross income exceeds \$_____ for my family size of _____.

Parent Printed Name _____

Parent Signature _____ Date _____

SCOE Distribution: Copy-Family File

Original & Income Calculation Worksheet- Parent

7/10/2025

State/PA_19.1

PARENT NOTIFICATION: REQUIREMENT TO REPORT INCOME OVER 100% THRESHOLD

Our records indicate that your family's basis for eligibility is income. The regulations require a family to report when their income exceeds the exit threshold. The income ceilings are based on family size and a family's adjusted gross income (Income before taxes). Effective July 1, 2025, the CDE Early Education Division exit thresholds are as follows:

Family Size	Family Monthly Income	Family Yearly Income
1-2	\$8,071	\$96,854
3	\$9,159	\$109,904
4	\$10,612	\$127,338
5	\$12,309	\$147,712
6	\$14,007	\$168,086
7	\$14,326	\$171,906
8	\$14,644	\$175,726
9	\$14,962	\$179,547
10	\$15,281	\$183,367
11	\$15,599	\$187,187
12	\$15,917	\$191,007

My signature below acknowledges that I understand it is my responsibility to notify Stanislaus County Office of Education within 30 calendar days if, and when my adjusted **monthly** gross income exceeds \$ _____ for my family size of _____.

Parent Printed Name _____

Parent Signature _____ Date _____

COE Distribution: COPY-Family File

Original & Income Calculation Worksheet- Parent

Date: _____

Parent Name: _____

Child Name: _____

Family Language Instrument (A)

1) Which language(s) is/are your child hear and/or exposed to at home?

This includes the language(s) spoken or signed by parents, grandparents, siblings, extended family, or others living within or visiting the home, including ASL and other sign languages.

2) Which language(s) does your child hear, and/or is exposed to in their neighborhood and community?

For example, with friends and neighbors, or at after school programs or activities, what language(s) does your child hear or is your child exposed to. This is to demonstrate language exposure, not to measure language proficiency.

3) Which language(s) does your child understand and/or respond to?

Children may demonstrate understanding in nonverbal ways such as with physical responses, facial expressions, and/or gestures. For example, when asked to put on their shoes, the child does so; when asked if they like how the food tastes, the child nods their head; when looking at a photo of their family and asked, "Where is grandma?" the child points to their grandmother in the photo.

4) Which language(s) does your child understand and/or use to communicate?

Children may demonstrate communication through various means, including using single words, parroting, signing, and using communication boards.

_____ (initials) I opt-out of completing the Family Language Instrument and or participating in the Family Language and Interest Interview.

FES: IF QUESTIONS 1, 3, OR 4 HAVE ANOTHER LANGUAGE OTHER THAN ENGLISH, MARK DLL PART B ON MASTER ENROLLMENT GOOGLE SHEET TO ENSURE ASSIGNED FAMILY ADVOCATE WILL REACH OUT TO PARENT FOR ADDITIONAL RESOURCES.

CHILD & FAMILY SERVICES EMERGENCY CARD

Tarjeta de emergencia de servicios para niños y familias

MEDIC ALERT

(Alerta médica)

Health Concern

(Preocupación de salud)

☐ Yes ☐ No

Si

No

(Asthma, Allergies, Medications, Health Problems: List/Lista _____)

Is there a court order regarding custody of the child?

(¿Existe una orden judicial sobre la custodia del niño/a?)

☐ Yes ☐ No

(Si)

(No)

Child's Name

(nombre de niño)

(Last/ Apellido)

(First/ Primer Nombre) (MI)

(DOB/nacimiento)

Mailing Address

(Dirección de envío)

(Street Address/ Dirección)

(City/ Ciudad)

(State/ Estado)

(Zip/ Código postal)

Physical Address

(Dirección física)

(Street Address/ Dirección)

(City/ Ciudad)

(State/ Estado)

(Zip/ Código postal)

Mother/Madre

Guardian

(Last/ Apellido)

(First/ Primer Nombre)

(DOB/nacimiento)

Father/Padre

Guardian

(Last/ Apellido)

(First/ Primer Nombre)

(DOB/nacimiento)

Child's Doctor /Hospital to be called in case of emergency

(Médico/hospital al que se debe llamar en caso de emergencia)

Phone

(Teléfono)

Address

(Dirección)

☐ MediCal ☐ Healthy Families ☐ None ☐ Private (name) (check one)
 (nombre) (marca uno)

Child's Insurance #

(Número de seguro médico del niño/a)

Service Options: ☐ Center Based

☐ Home Based ☐ FCCH

Location: _____

Phone: _____

Teacher: _____

Preferred Language: _____

Mother(Madre)/Guardian Contact Info:

Home Phone: _____
(Teléfono de casa)

Work Phone: _____
(Teléfono del trabajo)

Cell Phone: _____
(Teléfono móvil)

Father(Padre)/Guardian Contact Info:

Home Phone: _____
(Teléfono de casa)

Work Phone: _____
(Teléfono del trabajo)

Cell Phone: _____
(Teléfono móvil)

Permission for Medical Treatment: As the child's parent or legal guardian, I understand that in the case of my child's medical emergency, the center will call 911 and then notify me. I consent to my child's being transported to a physician or licensed medical facility. I give permission for diagnosis, treatment, and/or care which in the best judgement of the physician or dentist, may be required. This permission is valid for this school year as long as the child remains in the Head Start/State program.

Consentimiento para Tratamiento Médico: Como el padre/la madre o tutor legal del niño/a, entiendo que en caso de una emergencia médica, el personal del centro primero llamará al 911 y despues me notificara. Doy consentimiento que se transporte mi niño/a a un consultorio médico para diagnosis, tratamiento, y/o cuidado cual sea necesario según el juicio del médico o odontólogo. Éste consentimiento será válido durante el año escolar en curso o mientras el niño/a continúe en el Programa Head Start/State.

Signature/Firma _____ Date/Fecha _____
(Parent or Guardian) (Padre o Tutor)

Signature/Firma _____ Date/Fecha _____
(Parent or Guardian) (Padre o Tutor)

File Original Copy in the Emergency Binder

Mandatory
 Revised 12/22
 CF/ERSEA-20

CHILD & FAMILY SERVICES EMERGENCY CARD

Tarjeta de emergencia de servicios para niños y familias

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Emergency Contacts: If parents are not available, the following persons are authorized to drop children off and take child(ren) from the facility, or be called in case of emergency. The child(ren) will **NOT** be able to leave with **ANY OTHER PERSON** without written authorization from the parent/guardian.

Contactos de emergencia: Si los padres no están disponibles, las siguientes personas están autorizadas a dejar a los niños y sacarlos de la instalación, o ser llamados en caso de emergencia. Los niños **NO** podrán irse con **NINGUNA OTRA PERSONA** sin la autorización por escrito del padre/guardián.

Name / Nombre	Relationship /Relación	Phone / Teléfono	Signature / Firma
1.			
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