Stanislaus County Office of Education
Scott Kuykendall, Superintendent

Child & Family Services
Tony Jordan, Executive Director
1325 H Street • Modesto, CA 95354 • (209) 238-6300 FAX (209) 238-4217

APPLICATION PROCESS
CALIFORNIA ALTERNATIVE PAYMENT PROGRAM (CAPP)

You were recently screened for potential enrollment. Thank you for your interest in CAPP.

CAPP is a reimbursement program. The program reimburses the families' identified provider *(which can be a licensed facility, family childcare home, family, friend or neighbor)* directly for approved certified childcare services. Families must follow the application process in order to enroll in the program. Going through the application process is not a guarantee for enrollment. If information provided during the screening was misleading or inaccurate the family may not be eligible for the program.

STEP 1: Parent completes "CAPP: How to Apply" In Person or Online.

Enrolling Program Title: Alternative Payment Program (Light blue)
Website: https://www.findchildcarestanislaus.org/step2submitdocuments
Website Password: CFS

STEP 2: Parent Completes Forms, Gathers Documents listed on the checklist, **Selects a Child Care Provider** and **Completes the CAPP Parent Orientation** (Instructions for accessing orientation are included in the enrollment packet. Orientation outlines ongoing participation requirements once enrolled in the program).

In order to complete an application, the parent must have a provider selected and the provider MUST be active with CAPP. CAPP is a parental choice program; the family is responsible for identifying their provider. For additional information on provider options, families are encouraged to contact their assigned Specialist at 209-238-6300 or Resource and Referral at 209-238-6400. The parent must confirm their identified provider with their assigned specialist. If the provider is not active with CAPP, the specialist will provide information on how the identified provider can become an approved CAPP provider.

When identifying a provider, families are encouraged to review the reimbursement ceilings for this program. The reimbursement ceilings can be found at https://rcscc.adm.dss.ca.gov/. If the identified provider's rates are in excess of the maximum reimbursement amount listed for Stanislaus County, the excess is the family's responsibility.

STEP 3: Parent calls assigned Family Eligibility Specialist at (209) 238-6300 to request a digital form or schedule an appointment in order to submit completed documentation. *If parent does not contact their assigned Family Eligibility Specialist within 2 weeks of being screened, they will not be eligible for this enrollment period.*

STEP 4: Parent and Family Eligibility Specialist Complete Application. Application will be completed at in-person appointment or through digital form. An application cannot be completed with incomplete documentation. An approved CAPP provider is required in order to complete application.

STEP 5: Family Eligibility Specialist will mail a Notice of Action within 30 days approving or denying services. If services are approved, a Certificate for Childcare Services and Attendance Claim will be mailed to the provider. Child begins care based on the approval date on the Notice of Action. Childcare services used before being approved are the parent's responsibility. Approvals cannot be issued until both the parent and Family Eligibility Specialist sign a completed application. Approvals are not backdated.

If at any time you have any questions, please call your assigned Family Eligibility Specialist at (209)238-6300.
We look forward to working with you!

Revised 2/23/2024

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CALIFORNIA ALTERNATIVE PAYMENT PROGRAM (CAPP)
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 (Example: CalWORKs Notice of Action or CalWORKs 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
  - ☐ Income documentation from all sources
    - Predictable Income: Gross Income from the month or two proceeding certification.
    - Unpredictable Income: Gross Income for the preceding 2-12 months

    (Seasonal, agricultural, includes bonuses or commission provide a minimum of 2 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
- ☐ Adoption documents
- ☐ Court orders regarding child custody or guardianship

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 & Class Schedule
- ☐ Educational Program Verification
- ☐ 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 Needs Request & Referral
- ☐ Identification & Emergency Information for each enrolled child
- ☐ Family Information Form
- ☐ Provider Information Form
- ☐ CAPP Orientation Knowledge Check Form
- ☐ Parent Notification: Requirement to Report Income Over 85% of SMI (if eligibility is income)
- ☐ Parent Authorization and Handbook Receipt
- ☐ 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.

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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 at a minimum two but can elect to submit up to twelve months gross income.

Countable Income Sources	Non-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 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.
1. Gross wages, salary, advances, commissions, overtime, tips, bonuses, gambling or lottery winnings 2. Wages for migrant, agricultural, or seasonal work 3. CalWORKs cash aid 4. Gross income from self-employment less business expenses with the exception of wage draws 5. Disability or unemployment compensation 6. Worker's compensation 7. 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 8. Survivor (i.e. SSA) and retirement benefits 9. Rent for room within the family's residence 10. Dividends, interest on bonds, income from estates or trusts, net rental income or royalties 11. Financial assistance received for the care of a child living with an adult who is not the child's biological or adoptive parent 12. Veteran's pension 13. Pension or annuities 14. Inheritance 15. Allowances for housing or automobiles provided as part of compensation 16. Insurance or court settlements for lost wages and/or punitive damages 17. Net proceeds from the sale of real property, stocks or inherited property 18. Other enterprise for gain	1. Earnings of child under eighteen (18) years 2. Loans 3. Grants or scholarships to students for educational purposes 4. Federal Supplemental Assistance Program (CalFRESH/SNAP) or Women, Infants and Children (WIC) benefits or other food assistance 5. Earned Income Tax Credit or tax refund 6. Foster care grants, payment or clothing allowances for children placed through child welfare services 7. Relative Caregiver Funding Program 8. California Guaranteed Income Pilot Program 9. GI Bill entitlements, hardship or hazardous duty, hostile fire or immediate danger pay 10. Adoption assistance payments 11. Non-cash assistance or gifts 12. All income of any individual counted in the family size who is collecting federal Supplemental Security Income (SSI) or State Supplemental Program (SSP) benefits 13. Insurance or court settlements including pain and suffering and excluding lost wages and punitive damages 14. Reimbursements for work-required expenses that include uniforms, mileage, or per diem expenses for food and lodging 15. Business expenses for self-employed family members 16. 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 17. Disaster relief grants or payments, except any portion for rental assistance or unemployment 18. 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*

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FAMILY INFORMATION FORM

PLEASE PRINT CLEARLY AND <u>COMPLETE THOROUGHLY</u>

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

Parent/Guardian (A)

Name: _____

Birth Date: _____

Gender: ☐ Female ☐ Male

Race (Must select at least one):
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Caucasian
☐ Native Hawaiian or Other Pacific Islander

Primary Home Language: _____

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino

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

Email Address: _____

Phone Number: _____

Need for Service:
☐ Actively Seeking Employment
☐ Employed / Self Employment
☐ School / Training
☐ CPS/At Risk
☐ Incapacitated
☐ Homeless

Military Status
If you are on active duty in the military or a current member of the national guard or military reserve.
Indicate branch_____

Parent/Guardian (B)

Name: _____

Birth Date: _____

Gender: ☐ Female ☐ Male

Race (Must select at least one):
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Caucasian
☐ Native Hawaiian or Other Pacific Islander

Primary Home Language: _____

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino

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

Email Address: _____

Phone Number: _____

Need for service:
☐ Actively Seeking Employment
☐ Employed / Self Employed
☐ School / Training
☐ CPS/At Risk
☐ Incapacitated
☐ Homeless

Military Status
If you are on active duty in the military or a current member of the national guard or military reserve.
Indicate branch_____

Other individual(s) under 18 years old in the home that will **<u>not be enrolled</u>** on the program and are counted in family size. Please skip to page 2 if all children are enrolling. Attach documentation (court order, birth certificate etc.) that links children to parent A or B.

Name	Relationship to Parent(s)/Guardian(S)/Gender	Birth Date	Race/Ethnicity

Revised 8/21/2025
State/PA14.1

Complete one column per child needing childcare. Attach additional pages as needed.

Child Name: _____

Birth Date: _____

Gender: ☐ Female ☐ Male

Race (Must select at least one):
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Caucasian
☐ Native Hawaiian or Other Pacific Islander

Primary Home Language: _____

Ethnicity:
☐ Not Hispanic or Latino
☐ Hispanic or Latino

Special Needs: ☐ Yes ☐ No
If yes, attach current IEP or IFSP

Relationship to Parent/Guardian: _____

School Name and grade: (Early Education or Elementary School) _____

School Hours
(i.e. M, T, Th F 8am-2pm, W 8am-12pm): _____

If starting school in the next 24 months indicate month/year start date: _____

(CAPP) Child Care Provider Name: _____

<u>Childcare will be approved based on verified need.</u> Specify the days and hours you are requesting childcare with above provider.

School Days: available for all children. If child is enrolled in an early education or is eligible to attend elementary school only include time before and after school needed. **Days and hours requested:**

_____
_____
_____

Vacation Days: only available if child is enrolled in an early education or age eligible for elementary school and childcare is needed when the school is closed. **Child non-school days and hours requested:**

_____
_____
_____

Child Name: _____

Birth Date: _____

Gender: ☐ Female☐ Male

Race (Must select at least one):
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Caucasian
☐ Native Hawaiian or Other Pacific Islander

Primary Home Language: _____

Ethnicity:
☐ Not Hispanic or Latino
☐ Hispanic or Latino

Special Needs: ☐ Yes ☐ No
If yes, attach current IEP or IFSP

Relationship to Parent/Guardian: _____

School Name and grade level: (Early Education or Elementary School) _____

School Hours
(i.e. M, T, Th F 8am-2pm, W 8am-12pm): _____

If starting school in the next 24 months indicate month/year start date: _____

(CAPP) Child Care Provider Name: _____

<u>Childcare will be approved based on verified need.</u>
Specify the days and hours you are requesting childcare with above provider.

School Days: available for all children. If child is enrolled in an early education or is eligible to attend elementary school only include time before and after school needed. **Days and hours requested:**

_____
_____
_____

Vacation Days: only available if child is enrolled in an early education or age eligible for elementary school and childcare is needed when the school is closed. **Child non-school days and hours requested:**

_____
_____
_____

Parent/Guardian Signature_____ **Date**_____

Stanislaus County Office of Education
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PROVIDER INFORMATION FORM

TO BE COMPLETED BY THE PARENT/GUARDIAN

Print Parent/Guardian Name _____ **Phone Number**_____

Request (Select One)**:**

- ☐ Initial provider (First enrollment for family/child)
- ☐ Change in child care provider (Note: Must be approved 2 weeks in advance)
  Previous provider name _____ Last date of service_____
- ☐ Alternate provider (Note: Must be approved 2 weeks in advance and limited to 10 days per fiscal year)
  Service dates _____ to _____
- ☐ Adding a second provider

List child(ren) affected by this request and the day/time care is needed:

Child Name	**Day/Time–Non-school days**	**Day/Time–School days**
Jane Doe	*Mon – Fri 7:30am – 5:30pm*	*Mon – Fri 3:00pm – 5:30pm*
John Doe	*Vary Sun – Sat; max 6 hr per day*	*Vary Sun – Sat; max 3.5 hr per day*

_____ _____
(Parent/Guardian signature) **(Date)**

TO BE COMPLETED BY THE PROVIDER

Completing this section indicates you have room for the children identified above

Print Provider Name _____ **Phone Number** _____

Provider Address _____ **Tax ID#** _____

_____**First Date Child Care Services will be available for child (ren).**

Provider Type (Select One)**:**

- ☐ Licensed Center
- ☐ Licensed Family Child Care Home
- ☐ School Site Exempt
- ☐ Non Licensed, Exempt out of child's home
- ☐ Non Licensed, Exempt in child's home (Note: only available if the parent signs a self-attestation form acknowledging that they are assuming employer responsibilities for the in-home license exempt provider and acknowledge they are responsible for complying with any applicable federal and state employment laws. The approved reimbursement rates for Exempt Relative or Non Relative providers can be assessed by visiting https://rcscc.adm.dss.ca.gov/)

Note: New childcare providers must submit a copy of their policies/contract and rates. SCOE will be unable to contract with you if policies/contract and rates are not on file.

_____ _____
(Provider signature) **(Date)**

Provider Request Process

1) Parent/Guardian selects a child care provider
2) Parent/Guardian discuss' child care needs with Family Eligibility Specialist
3) Family Eligibility Specialist provides the parent/guardian with required documentation
    a. Exempt provider– Specialized packet depending upon type of exempt care
    b. Licensed or school site exempt – Provider Information Form only
4) Parent/Guardian and provider complete and submit required documentation to their Family Eligibility Specialist
5) Family Eligibility Specialist reviews requested action
    a. Complete documentation – Requested action will be effective 2 weeks from receipt of all documentation.
    b. Incomplete documentation – Returned to parent/provider for completion. Requested action will be effective 2 weeks from receipt of completed documentation.
6) A Certificate for Child Care Services and attendance claim is issued to the child care provider
7) Child care services may begin

Instructions for the Provider Information Form

Parent/Guardian section:

Parent/Guardian Name – Name of parent/guardian of enrolled child

Phone Number – Contact telephone number of parent/guardian

Request – Specify request

- Initial provider – Check this box if first enrollment for your family or child
- Change in child care provider – Check this box if your child(ren) are in the process of changing child care providers. Also, record your previous provider and the last date service was used.
- Alternate provider – Check this box if you are requesting to have an alternate provider for when your child is ill or when your regular provider is closed. Also, record the childcare service dates for the alternate provider.
- Adding a second provider – Check this box to add a second provider because one of the providers can not accommodate all of your child care needs or if you have elected to enroll your child(ren) in a licensed early education program for a half day.

List child(ren) affected by the request and the day/time care is needed – List only the children in your family who will be affected by the action. Also, record the day/time child care is needed with this provider.

Provider section:

Provider Name – Name of childcare provider that will provide services

Phone Number – Contact telephone number of the childcare provider that will provide services

Provider Address – Physical and mailing address of child care provider

SS# or Tax ID# - Providers social security number or tax id number

First Date of Service for child(ren) – Record the first date child care services will start

Provider Type – Check the appropriate box of the provider type that will be providing childcare services

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FAMILY NEEDS REQUEST & REFERRAL

Parent(s)/Guardian(s): _____

In an effort to assist you in meeting your unique family needs, we ask your cooperation in completing this form. This information will allow program staff to provide you with information about resources available. Indicate your top three (3) referral needs by ranking them in order of 1-3 (**1 being of greatest priority)**. If you do not need referrals, check here ☐ and sign below.

___ Medical	___ Utility Assistance	___ Legal Services	___ Employment Opportunities
___ Dental	___ SSI / Social Security	___ TANF / Cash Aid	___ Vocational Training
			College (Specify Type):
___ CPR – First Aid	___ Driver's License	___ Food Stamps	___ _____
___ Family Counseling	___ Child Care Referrals	___ ESL	___ GED / Diploma
___ Children's Special Needs	___ Housing Assistance	___ Immigration	___ Other:_____
___ Emergency Food & Clothing	___ Renter's Rights	___ Unemployment	

1 Referrals		2 Referrals		3 Referrals	
Agency:		Agency:		Agency:	
Address:		Address:		Address:	
Phone:		Phone:		Phone:	
Website:		Website:		Website:	

Parent Signature Date

Staff Signature Date

FOR OFFICE PURPOSES ONLY (GCC/FCCHEN)

Follow-up:

Date	Staff Initials	Notes

White- Family File Yellow- Parent

Stanislaus County Office of Education
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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, 2024, the exit thresholds are as follows:

Family Size	Family Monthly Income	Family Yearly Income
1-2	6,595	79,143
3	7,472	89,660
4	8,712	104,544
5	10,106	121,271
6	11,500	137,998
7	11,761	141,134
8	12,023	144,270
9	12,284	147,407
10	12,545	150,543
11	12,807	153,679
12	13,068	156,816

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 _____

Child(ren) Name(s) _____

Parent Signature_____ Date_____

SCOE Distribution: Copy-Family File Original & Income Calculation Worksheet- Parent

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEPHONE
					( )

ADDRESS	NUMBER	STREET	CITY	STATE	ZIP	BIRTHDATE

FATHER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE
				( )

HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP	HOME TELEPHONE
						( )

MOTHER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE
				( )

HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP	HOME TELEPHONE
						( )

PERSON RESPONSIBLE FOR CHILD	LAST NAME	MIDDLE	FIRST	HOME TELEPHONE	BUSINESS TELEPHONE
				( )	( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE
			( )

DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE
			( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT OR AUTHORIZED REPRESENTATIVE	DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEPHONE
					( )

ADDRESS	NUMBER	STREET	CITY	STATE	ZIP	BIRTHDATE

FATHER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE
				( )

HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP	HOME TELEPHONE
						( )

MOTHER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE
				( )

HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP	HOME TELEPHONE
						( )

PERSON RESPONSIBLE FOR CHILD	LAST NAME	MIDDLE	FIRST	HOME TELEPHONE	BUSINESS TELEPHONE
				( )	( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE
			( )

DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE
			( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT OR AUTHORIZED REPRESENTATIVE	DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT

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PARENT AUTHORIZATION AND RECEIPT FORM

Authorization

I give permission to Stanislaus County Office of Education (SCOE) and its representative to verify any and all information utilized to determine my family's eligibility. My signature below gives SCOE and its representative permission to verify employment status, training status, incapacitation status and any other information necessary to establish my eligibility for enrollment and reimbursement of my child care services.

If the information given by, or on my behalf during the certification process is found to be false or inaccurate, I will be responsible for repayment to SCOE.

Receipt

I acknowledge that I understand the most current Program Parent/Provider Handbook is accessible by visiting the following webpage https://www.findchildcarestanislaus.org/cfsparents (password CFS). If at any time I would like a hard copy of the handbook, I can request a printed copy from program staff. I understand that it is my responsibility to access, read and comply with the rules and regulations contained in program's handbook. I acknowledge that failure to do so may result in the discontinuation of my child care services and a one (1) year penalty from the program.

Please print, sign your name, and return this form to:

Stanislaus County Office of Education
Child & Family Services
1325 H Street #005
Modesto, CA 95354

_____
Parent Printed Name

_____
Parent Signature

_____
Date

If you have any questions, please call (209) 238-6300.

Distribution: White-Family File Yellow-Parent

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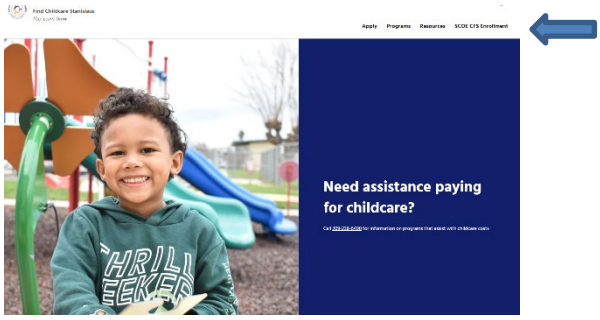
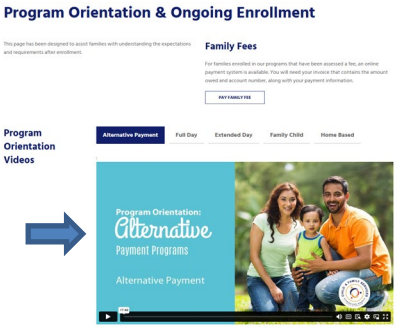
CAPP Parent Orientation

Parent Name: _____ **Date:** _____

STEP 1: Watch Alternative Payment Program Orientation Video

Visit: https://www.findchildcarestanislaus.org/
Select: SCOE CFS Enrollment
Select: Program Orientation and Ongoing Enrollment
Select: Alternative Payment Program (Light Blue)





Note: To view subtitles in the video, press CC and select subtitle language.

Record questions (The Family Eligibility Specialist will answer any of your questions at your in-person meeting):

_____

_____

STEP 2: Complete Knowledge Check

1) All adults counted in the family size must have a need for services. True or False

2) To increase days or hours between certification periods, the _____ form and _____ is required.

3) If you plan to change providers, how long does it take for the submitted request to be approved? _____ weeks

4) The authorized adult is required to **sign with full signature** and record the **exact time in/out** of care **daily**. True or False

5) If my child is absent from care, the attendance claim must include the reason for absence and signature. True or False.

6) Claims submitted to our office will be processed and reimbursement will be issued within 21 calendar days. True or False

7) If you disagree with an action, such as being terminated, what should you do? _____

8) If family has a family fee, a NOA to discontinue services will be issued if payment is not received by the 7th of the month. True or False

9) Any difference between what the provider charges and what the program may reimburse is the parents' responsibility. True or False

STEP 3: Review Handbook

☐ I will review the Alternative Payment Program Handbook online through findchildcarestanislaus.org. I understand it is my responsibility to review the handbook online.

or

☐ I will review the Alternative Payment Program Handbook. Please mail me a copy of the Alternative Payment Program Handbook. I understand it is my responsibility to review the handbook. Date Mailed:_____

Parent Signature: _____

Return this completed form with your Recertification Packet

Stanislaus County Office of Education
Scott Kuykendall, Superintendent

Child & Family Services
Tony Jordan, Executive Director
1325 H Street • Modesto, CA 95354 • (209) 238-6300 FAX (209) 238-4217

REQUEST & PLAN TO ACTIVELY SEEK EMPLOYMENT

Parent Name: _____

I want to actively seek employment on the following days and times. This serves as my request to seek employment. I am requesting childcare services necessary in order for me to secure, change or increase my employment. I understand that child care and development services for seeking employment can be approved for no more than 5 days per week and for less than 30 hours per week.

Requested Start Date:_____

☐ Check if requesting varied scheduled. Days and hours may vary, not to exceed the 5 days listed below and no more than 30 hours a week. Ensure to add days of the week requesting within chart below.

Day of Week	Start & End Times
	am/pm to am/pm
	am/pm to am/pm
	am/pm to am/pm
	am/pm to am/pm
	am/pm to am/pm

NOTE: Family Eligibility Specialist will review your request and will determine your approved childcare schedule. Approved childcare schedule will be based on your providers operating hours and your plan to secure, change or increase employment.

Plan to gain employment. **In detail, describe your plan to secure, change or increase employment. I will,**

_____

_____

_____

Note: To increase days or hours between certification periods, documentation of need to support the increase and Request for Change form is required. For example, if you gain employment and need more days or hours of childcare services, an Employment Verification and Request for Change form must be submitted. Increases in days/hours will not be backdated.

I swear under penalty of perjury, to the best of my knowledge, that the above information is correct.

Parent Signature _____ **Date** _____

Office use only. Explanation, if applicable, of why approved certified hours vary from parent request:

_____

_____

_____

_____

Revised 10/26/2021
State/PA 3.1
2 Pt NCR (White: Agency Pink: Parent)

Stanislaus County Office of Education
Scott Kuykendall, Superintendent

Child & Family Services
Tony Jordan, Executive Director
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EDUCATIONAL PROGRAM VERIFICATION

Educational Program Verification form & class schedule is required at the time of initial certification or recertification. To increase days and/or hours between certification periods, a new Need Verification & Request to Change Services form is needed. Note: **Increases in days/hours will not be backdated.**

PARENT/GUARDIAN INFORMATION

Parent/Guardian First and Last Name (Print) _____ Phone Number _____

Street Address _____ City _____ Zip Code _____

I am engaged in the following:

- ☐ Educational program for English Language Learners
- ☐ Program to obtain a High School Diploma
- ☐ Program to obtain a High School Equivalency Certificate

Stanislaus County Office of Education **has permission to contact my education institution** to verify my information.

Parent/Guardian Signature _____ Date _____

EDUCATION PROGRAM SCHOOL/INSTITUTION INFORMATION

Name of School/Institution where Education is Received _____ Phone Number _____

Street Address _____ City _____ Zip Code _____

Student will begin classes on _____
Start Date

STUDY TIME REQUEST

If needed, you may request study time. Indicate one of the below:

- ☐ I do not need child care services for study time
- ☐ I would like to request study time for the following days and times: _____.
  If available, attach documentation of the schools recommended study time. *(Example: Mon & Wed 1pm-3pm)*

CLASS SCHEDULE VERIFICATION

Complete **ONE** of the following to verify your current class schedule:

- ☐ Attached is an electronic printout of the student's class schedule from the education program school/institution, **or**
- ☐ Below is the student's class schedule with the signature and/or stamp of the School/Institution Registration office.

Day	Time	Room #	Course Name	Estimated Weekly Study Time
Signature and/or Stamp from the School/Institution Registrar				
Date of Signature and/or Stamp				

OFFICE USE ONLY

Date	Staff Initials	Approved Class Time (Based on Class Schedule)	Approved Study Time (Check with school to determine reasonable hours)	Approved Travel Time (Time needed to & from services & school. Not to exceed ½ of the weekly class hours with a max of 4 hours per day)

Stanislaus County Office of Education
Scott Kuykendall, Superintendent

Child & Family Services
Tony Jordan, Executive Director
1325 H Street • Modesto, CA 95354 • (209) 238-6300 FAX (209) 238-4217

REQUEST & PLAN TO SEEK PERMANENT HOUSING

Child care services for the purpose of seeking permanent housing may occur no more than 5 days per week and for less than 30 hours per week.

Note: To increase days and hours between certification periods, documentation of need to support the increase and Request to Change Services form is required.

CURRENT LIVING SITUATION

Describe your current living situation: _____

_____

_____

REQUEST TO SEEK PERMANENT HOUSING

This serves as your request to seek permanent housing. Please describe when child care services are necessary for you to secure a fixed, regular and adequate residence.

Day	Start and End Times
	am/pm to am/pm
	am/pm to am/pm
	am/pm to am/pm
	am/pm to am/pm
	am/pm to am/pm

Start Date _____

◯ Check this circle if your days/hours will vary.

NOTE: Family Eligibility Specialists will review request and determine the child care schedule.

PLAN TO SEEK PERMANENT HOUSING

Describe your plan to secure a fixed, regular and adequate residence: _____

_____

_____

I swear under penalty of perjury that the information contained in this document is true and correct.

_____ _____ _____
PRINT PARENT/GUARDIAN NAME PARENT/GUARDIAN SIGNATURE DATE

Revised 10/27/2021
State/PA_20.1

Stanislaus County Office of Education
Scott Kuykendall, Superintendent

Child & Family Services

Tony Jordan, Executive Director
1325 H Street • Modesto, CA 95354 • (209) 238-1800 FAX (209) 238-4217

EMPLOYMENT VERIFICATION

AUTHORIZATION TO RELEASE EMPLOYMENT INFORMATION

Parent/Guardian First and Last Name (Print) _____ Company Phone Number _____

Company Business Name _____ Company Contact Name _____ Fax Number _____

Company Street Address _____ City _____ Zip Code _____

Company Usual Business Days _____ Company Usual Business Hours _____

Check only one box:

- ☐ **Stanislaus County Office of Education has permission to contact my employer** to verify my employment and income information. (Attach paystub and provide to employer to complete)
- ☐ I declare under penalty of perjury that my employer has refused or failed to provide requested employment Information. (Attach paystub & self-complete employer information.)
- ☐ I declare under penalty of perjury that contacting my employer would adversely affect my employment. (Attach paystub and self-complete employer information)

Parent, if requesting additional travel or sleep time, please also complete request on backside of form.

Parent/Guardian Signature _____ **Date** _____

EMPLOYMENT INFORMATION

In order to provide childcare services to your employee, we must have verification of their employment. If you have any questions about the completion of this form, please contact a Family Eligibility Specialist at (209) 238-6300.

Date of Hire _____ Employee's Current Position _____ Start Date of Current Position _____ Work Site Location _____

If the employee is returning from a leave, what is the date of return? _____

Specify if the employee works a set or variable schedule:

◯ **SET SCHEDULE** – Please specify the employee's set work schedule for each day (Example: Monday 8am-5pm)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

◯ **VARIABLE SCHEDULE** – Please specify the employee's variable work schedule

Possible days the employee may work (check all that apply): ◯ M ◯ T ◯ W ◯ Th ◯ F ◯ Sa ◯ Su

Earliest work start time: _____ (Ex. 6:00am) Latest work end time: _____ (Ex. 6:00pm)

Minimum number of hours worked per day: _____ (Ex. 4 hours) Maximum number of hours worked per day: _____ (Ex. 8 hours)

Minimum number of days worked per week: _____ (Ex. 3 days) Maximum number of days worked per week: _____ (Ex. 5 days)

How often does the employee work overtime: ◯ Never ◯ Often ◯ Occasionally

Specify the employee's wage information:

Paid by: ◯ Paycheck ◯ Cash ◯ Personal Check **Pay Rate**: $_____ (Ex. $10.00) per _____ (Ex. Hour/Day/Week/Month)

Pay Period: ◯ Daily ◯ Weekly ◯ Every two weeks ◯ Twice per month ◯ Monthly

Does the employee receive any of the following: ◯ Overtime ◯ Commission ◯ Tips ◯ Bonus ◯ NA

Name of Person Completing Form _____ Title _____ Signature _____ Date _____

PARTICIPANT TRAVEL TIME REQUEST (if applicable)

In order to provide childcare services for travel time, please compete the request below:

Specify the length of time it takes to travel one way to your work site: _____

Please explain why you need additional travel time to and from your work site: _____

_____

I swear under penalty of perjury, to the best of my knowledge, that the information above is true and correct.

_____ _____
Parent/Guardian Signature Date

PARTICIPANT SLEEP TIME REQUEST (if applicable)

Sleep time may be requested if a parent works between the hours of 10:00pm - 6:00am. Hours requested may not exceed the equal number of employment and travel time that falls between 10:00pm-6:00am. If applicable, please complete the sleep time request below:

Specify days and hours childcare services are needed so that you can sleep:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

I swear under penalty of perjury, to the best of my knowledge, that the information above is true and correct.

_____ _____
Parent/Guardian Signature Date

PARTICIPANT JUSTIFICATION FOR CHILDCARE IF WORK SITE IS HOME (if applicable)

Specify if your work address is the same as your residence, the type of work, work requirements, ages of children and conditions that preclude you from caring for your child. _____

_____

_____

FOR OFFICE PURPOSES ONLY

Date Verified	Verified With	Staff Initials	Notes

- ☐ Regular/Stable Schedule (Set Schedule or Variable Schedule with a Pattern)
- ☐ Inconsistent/Unstable Schedule (No pattern. Calculate the maximum number of hours of need based on the week with the greatest number of hours from either month of the two-month window immediately preceding certification)
- ☐ Attestation, if unable to contact employer: I, _____, attest that the reported income and employment is reasonable or consistent with community practice.

Stanislaus County Office of Education
Scott Kuykendall, Superintendent

Child & Family Services
Tony Jordan, Executive Director
1325 H Street • Modesto, CA 95354 • (209) 238-6300 FAX (209) 238-4217

SELF-EMPLOYMENT SELF ATTESTATION OF COUNTABLE INCOME

In order to provide childcare services for a self-employed person, we are required to verify the work activities and income. In addition to the Self Employment Verification, please complete this form and attach supporting documentation to help us determine your income eligibility.

Month/Year	Gross Income (A) (attach support documentation)	Business Related Deductions (B) (attach support documentation)	Adjusted Gross Countable Income (C) (Gross income subtract business related deductions equals adjusted Gross income. A-B=C)

Attach documentation to support your self-attested calculation of your self-attested business income. (Attach all that apply):

	Receipts for Expenses		Invoices for Product		Invoices for Services
	Tax Returns		Receipts for Product		Quarterly Tax Statement
	Business Profit Statement		Business Loss Statement		Receipts for Services

I swear under penalty of perjury, to the best of my knowledge, that the above information is true and correct. I understand that this Self-Certification of Income is part of an application for services for a program that is paid for with state and/or federal funds. I understand that intentionally providing misleading, inaccurate or untruthful information of a material nature could result in termination of services for my child enrolled in any State or Head Start program and could have serious legal consequences for me.

_____ _____
Parent/Guardian Signature Date

FOR OFFICE PURPOSES ONLY: Staff signature below attests that the parent/guardian's reported income and if applicable Self-Employment is reasonable and/or consistent with community practice.

Date Verified	Staff Initials	Indicate steps taken to verify information

Stanislaus County Office of Education
Scott Kuykendall, Superintendent

Child & Family Services
Tony Jordan, Executive Director
1325 H Street • Modesto, CA 95354 • (209) 238-6300 FAX (209) 238-4217

SELF-EMPLOYMENT VERIFICATION FORM

In order to provide child care services for a self-employed person, we are required to verify the work activities and income. Please complete this form and attach supporting documentation to help us determine your eligibility:

Parent/Guardian First and Last Name (Print) _____ Business Phone Number _____

Business Name _____ Date Business Opened _____ Business Fax Number _____

Business Street Address _____ City _____ Zip Code _____

Type of Business (Describe your business. Example: Beautician, House Cleaning, Landscape, Real Estate etc.…) _____

Specify your work schedule (select one):

☐ **SET SCHEDULE** – I work the same schedule every week. Specify schedule for each day (Example: Mon 8am-5pm)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

☐ **FLUCTUATING SCHEDULE** – I work on a regular basis, but my days/hour vary. Specify work schedule

Possible days you may work (Check all that apply): ◯ M ◯ T ◯ W ◯ Th ◯ F ◯ Sa ◯ Su

Earliest work start time: _____ (Exp. 6:00am) Latest work end time: _____ (Exp. 6:00pm)

Minimum number of hours worked per day: _____ (Exp. 4 hours) Maximum number of hours worked per day: _____ (Exp. 8 hours)

☐ **VARIABLE SCHEDULE** - I work occasionally on an as needed basis.

Specify if your business address is the same as your residence, the type of work, work requirements, ages of children and conditions that preclude you from caring for your child._____

_____

_____

Specify your income information. Describe how you get paid and include price list for services.

_____

(Example: Per Job. $50 per house; 10% per sale, $25 for haircut, $35 Shampoo & cut, $45 mani/pedi)

Include contact information to verify sources of self-employment income: _____

_____

Attach documentation to verify your business activity and income. (Attach all that apply):

	Business License		Receipts for Expenses		Professional License
	Advertising Materials		Tax Return		Quarterly Tax Statement
	Rental/Lease Agreement		Appointment Log		Receipts for business expenses
	Business Card		Invoice for Service/Product		Business Profit/Loss Statement

I declare under penalty of perjury, that the information regarding my self-employment is true and correct. I give Stanislaus County Office of Education permission to request any information necessary to verify and support my days/hours worked by contacting clients, landlord or others deemed necessary.

Parent/Guardian Signature _____ Date _____

Stanislaus County Office of Education
Scott Kuykendall, Superintendent

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Tony Jordan, Executive Director
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PARTICIPANT TRAVEL TIME REQUEST (if applicable)

In order to provide childcare services for travel time, please compete the request below:

Specify the length of time it takes to travel one way to your work site: _____
Please explain why you need additional travel time to and from your work site:
_____
_____
_____
I swear under penalty of perjury, to the best of my knowledge, that the information above is true and correct.

_____ _____
Parent/Guardian Signature Date

PARTICIPANT SLEEP TIME REQUEST (if applicable)

Sleep time may be requested if a parent works between the hours of 10:00pm - 6:00am. Hours requested may not exceed the equal number of employment and travel time that falls between 10:00pm-6:00am. If applicable, please complete the sleep time request below:

Specify days and hours childcare services are needed so that you can sleep:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

I swear under penalty of perjury, to the best of my knowledge, that the information above is true and correct.

_____ _____
Parent/Guardian Signature Date

FOR OFFICE PURPOSES ONLY

Date employment and income Verified	Verified With	Staff Initials	Notes

☐ Regular/Stable Schedule (Set Schedule or Variable Schedule with a Pattern)

☐ Inconsistent/Unstable Schedule (No pattern. Calculate the maximum number of hours of need based on the week with the greatest number of hours from either month of the two-month window immediately preceding certification)

☐ Attestation: _____ attest that the reported income and employment is reasonable or consistent with community practice.

Stanislaus County Office of Education
Scott Kuykendall, Superintendent

Child & Family Services
Tony Jordan, Executive Director
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STATEMENT OF PARENTAL INCAPACITY

To be eligible for childcare & development services due to a physical or mental health condition preventing the parent/guardian from providing care or supervision for at least part of the day, annual verification by a licensed health professional is required.

PARENT/GUARDIAN RELEASE OF INFORMATION

To be completed by the incapacitated parent/guardian. By signing this form and for the purpose of verifying my incapacity to care for the family's children as it relates to the family's eligibility for subsidized childcare and development services, I authorize and request the health professional named below to release the information requested to the agency identified below. I further authorize the health professional to discuss this Statement of Parental Incapacity with the agency in order for the agency to verify, clarify, or complete it. I understand the health professional may also require that I complete his or her own release form prior to providing the information requested below.

NAME OF PARENT/GUARDIAN	SIGNATURE OF PARENT/GUARDIAN	DATE

FIRST NAME AND AGE OF THE CHILD(REN) FOR WHOM FINANCIAL ASSISTANCE FOR CHILD CARE IS BEING REQUESTED:

1.	2.	3.	4.

REQUESTING AGENCY INFORMATION

AGENCY	AUTHORIZED AGENCY REPRESENTATIVE (Please print.)	TELEPHONE NUMBER
Stanislaus County Office of Education		(209) 238-6300

ADDRESS	CITY	ZIP CODE
1325 H Street #005	Modesto	95354

LICENSED HEALTH PROFESSIONAL STATEMENT & VERIFICATION

To be completed by the licensed health professional. For the family to be eligible to receive childcare and development services under the category of incapacity, the California law requires annual verification of the physical or mental incapacity of the parent or guardian that renders the person incapable of caring for or supervising the family's child(ren) without assistance. *(See California Code of Regulations, Title 5, §18088.)* Your cooperation in completing and returning this form to the agency listed above within 15 days of receipt is requested.

PATIENT _____ has a physical condition **or** mental health condition that prevents him or her from providing care or supervision for the child(ren) listed above for at least part of the day.

Please indicate the time in a day and the days of the week, not to exceed 50 hours in a week, that the parent is unable to care for or supervise the child(ren).

Child care	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Start Time:	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm
End Time:	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm

If the time of day cannot be easily identified in consultation with the patient, please identify the number of hours ☐ and days of the week [M, T, W, T, F, S, S] that services are needed.

NAME OF LICENSED HEALTH PROFESSIONAL	LICENSE TYPE	LICENSE NUMBER
SIGNATURE OF LICENSED HEALTH PROFESSIONAL	DATE	TELEPHONE NUMBER ( )

MEDICAL GROUP OR ORGANIZATION WITH WHICH THE PROFESSIONAL IS AFFILIATED, IF ANY

ADDRESS	CITY	STATE	ZIP CODE

INSERT COUNTY LETTER HEAD

Date: _____

Attention: Family Eligibility Specialist
Stanislaus County Office of Education
1325 H Street #005
Modesto, CA 95354
Fax (209) 238-4217

This letter is a referral for child care and development services for the children of:

Parent/Guardian Name	Phone Number

The following children are (check one):

☐ at risk of abuse, neglect and/or exploitation. Child care and development services are needed to reduce or eliminate that risk.

☐ receiving child protective services and child care and development services are a necessary component of the child protective service plan.

Child's Name	Date of Birth	Days Per Week Care is Needed	Hours Per Day Care is Needed

The probable duration of the child protective services plan or at risk situation is_____months.

I recommend that the income ceiling and any applicable family fee be waived so this family may begin receiving services at the earliest possible date.
If you have any questions, please contact me at (209) 558-_____.

Sincerely,

_____
Name and Signature

_____
Title

SAMPLE HOMELESS REFERRAL LETTER
Insert Agency Letterhead Here
(Letter head must be from a legal, medical or socials service agency, a local educational agency Liaison for homeless children and youth, a head start program, or an emergency or transitional shelter)

Date:

ATTN: Stanislaus County Office of Education
1100 H Street #005
Modesto, CA 95354

This letter is a referral for child care and development services for the children of:

Parent(s)/Guardian(s) Name	Telephone Number

The children listed below are homeless based on the following criteria:

- ☐ Children are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason
- ☐ Children are living in motels, hotels, trailer parks, or camping grounds due to lack of alternative adequate accommodations
- ☐ Children living in emergency or transitional shelters
- ☐ Children have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings
- ☐ Children are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings
- ☐ Migratory children qualify as homeless because they are children who are living in similar circumstances listed above

Child care and development services are needed to support the family as follows:

Child's First & Last Name	Date of Birth	Days/Hours Needed
		Monday Tuesday Wednesday Thursday Friday (circle all days child care & development services are needed)
		Hours: (Example: 8:00am-5:00pm)
		Monday Tuesday Wednesday Thursday Friday (circle all days child care & development services are needed)
		Hours: (Example: 8:00am-5:00pm)
		Monday Tuesday Wednesday Thursday Friday (circle all days child care & development services are needed)
		Hours: (Example: 8:00am-5:00pm)

The probable duration of the Homeless situation is _____ months. According to EC section 8263(a) (1) (B) (i) (III), I declare that the family has a need for childcare due to their living situation. If you have any questions, please contact me at (123) 123-1234.

Sincerely,
John Doe
Title (Title must be from a legal, medical or socials service agency, a local educational agency Liaison for homeless children and youth, a head start program, or an emergency or transitional shelter)

Stanislaus County Office of Education
Scott Kuykendall, Superintendent

Child & Family Services
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TRAINING VERIFICATION

Training Verification form & class schedule is required at the time of initial certification. **At the time of recertification**, progress documentation is also required. To increase days and/or hours between certification periods, new Training Verification & Request to Change Services forms are needed. Note: **Increases in days/hours will not be backdated.**

PARENT INFORMATION

Parent First and Last Name (Print) _____ Phone Number _____

Street Address _____ City _____ Zip Code _____

I want to become a _____ by _____
Professional/Vocational Goal (Examples: Nurse, Welder, Cook, etc.…) Anticipated Completion Date

Stanislaus County Office of Education **has permission to contact my training institution** to verify my information.

Parent Signature _____ Date _____

TRAINING/EDUCATION INSTITUTION INFORMATION

Name of School or Institution where Training/Education is Received _____ Phone Number _____

Street Address _____ City _____ Zip Code _____

This term/semester/quarter begins on _____ and ends on _____
Term Start Date Term End Date

STUDY TIME REQUEST

If needed, you may request study time for a maximum of 2-3 hours per academic unit. Indicate one of the below:

- ☐ I do not need child care services for study time
- ☐ I would like to request study time for the following days and times: _____
  (Example: Mon & Wed 1pm-3pm)

PROGRESS VERIFICATION

Complete **ONE** of the following:

- ☐ **Initial Certification or New Student**: No records are needed at this time
- ☐ **Recertification**: Attach copy of report card, transcript or other training records from the most recently completed quarter, semester or training period showing progress

CLASS SCHEDULE VERIFICATION

Complete **ONE** of the following to verify your current class schedule:

- ☐ Attached is an electronic printout of the parent/guardian's course from the training organization
- ☐ Below is the parent/guardian's class schedule with the signature and/or stamp of the Registrar's office.

Day	Time	Room #	Course Name	Units	Credits
Signature and/or Stamp from the Training Institutions Registrar					
Date of Signature and/or Stamp					

In order to provide childcare services for travel time, please complete the request below. **Specify** the length of time it takes to travel one way to your school site:_____

Explain why you need additional travel time to and from your school site: _____

OFFICE USE ONLY

Date Verified	Verified With	Staff Initials	Notes (Verify adequate progress at recertification, 6-year maximum timeline and parent has not exceeded BA +24 units)