

SANTA MONICA MALIBU UNIFIED SCHOOL DISTRICT—Child Development
Services 2828 Fourth Street, Santa Monica, CA 90405 (310) 399-5865 Fax: (310) 396-1618
Application for ITC & Preschool
WWW.SMMUSD.ORG

Are you applying for financial assistance? NO _____ YES _____
If YES please fill out both pages of the form. ♦ If NO please fill out this page ONLY.

CHILDREN NEEDING PRESCHOOL:

1. **Child's Name:** _____ **Date of Birth:** _____ **Sex** ◯ **F** ◯ **M** **Grade** _____
2. **Child's Name:** _____ **Date of Birth:** _____ **Sex** ◯ **F** ◯ **M** **Grade** _____
3. **Child's Name:** _____ **Date of Birth:** _____ **Sex** ◯ **F** ◯ **M** **Grade** _____

Parent/Guardian 1's Name:	***Parent/Guardian 2's Name:***
► _____	► _____
Date of Birth: _____	**Date of Birth:** _____
Home Address: _____	**Home Address:** _____
City: _____ **State:** __ **Zip Code:**__ **Email**	**City:** _____ **State:** ___ **Zip Code:** _____
address: _____	**Email address:** _____
Home Phone Number: _____	**Home Phone Number:** _____
Cell Phone Number:	**Cell Phone Number:**
Parent/Guardian 1's Employer/School:	**Parent/Guardian 2's Employer/School:**
_____	_____
Work/School Address: _____	**Work/School Address:** _____
Work/School Phone Number: _____	**Work/School Phone Number:** _____

Child's Primary Home Language:	**Parent's Primary Home Language:**
English _____ Spanish _____ Other_____	English _____ Spanish _____ Other_____
Child's Race:	**Child's Ethnicity:**
☐ American Indian or Alaska Native ☐ Asian	☐ Hispanic or Latino
☐ Black or African American ☐ White	☐ NOT Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander	

► **Does your child have an IFSP or IEP (for Special Education)? Yes_____ No _____ (If yes, attach a copy of your child's IFSP/ IEP)**

☐ *Infant/ Toddler Center (0 -35 months)*

☐ John Adams CDC ☐ Washington West
☐ Lincoln CDC ☐ Undecided
☐ McKinley

Type of Preschool requesting:

☐ Part Day (3 hours)
☐ Full Day (Hours needed _____)

➪ ***Please check √ school year requesting:***
❒ ***2026-27*** ❒ ***2027-28***

_____ _____
Parent/Guardian's Signature **Date**

▶ SECTION BELOW MUST BE COMPLETED ONLY BY FAMILIES WHO ARE REQUESTING FINANCIAL ASSISTANCE

Number of children living at home: _____

Are you a single parent family? YES _____ **NO** _____

Parent/Guardian 1's monthly gross income (before taxes): _____

Parent/Guardian 2's monthly gross income (before taxes): _____

Are you or any member in your family receiving:

☐ Child Support $ _____ ☐ Unemployment $ _____ ☐ TANF/Cal WORKs $ _____ ☐ Medi-CAL

☐ Cal Fresh/Food Stamps $ _____ ☐ Healthy Families ☐ SSI ☐ WIC

☐ Other Income _____ Please specify _____

Is your family homeless? YES _____ NO_____

Is your child under the care of Child Protective Services? YES_____ NO_____

Do you have any other children enrolled in any state-subsidized program with SMMUSD?

NO____ YES _____→ Child's Name: _____ School: _____

Please list below all siblings in the household (*not those requesting preschool/childcare*):

Child's Name:	**Date of Birth / /**	**Sex F / M**	**School /Grade:**
Child's Name:	**Date of Birth / /**	**Sex F / M**	**School /Grade:**
Child's Name:	**Date of Birth / /**	**Sex F / M**	**School /Grade:**

Comments:

_____

_____.

_____ _____

Parent/Guardian's Signature **Date**

OFFICE USE ONLY:

DATE RECEIVED: _____ ***ELIGIBILITY #*** _____