



MENDOCINO COUNTY

ELIGIBILITY LIST

Application for Alternative Payment Childcare Services

PLEASE RETURN THIS FORM TO:

NCO/Rural Communities Childcare 111A Boatyard Drive Fort Bragg, CA 95437 707-964-5594 FAX 707-964-3080

1. FIRST PARENT	GUARDIAN INFORMATION						
Name of Parent	Home Phone						
Mailing Address							
Physical Address	Cell Phone						
CityZip Code	Parent Date of Birth						
Email Address:	Race/Ethnicity						
How did you hear about our services?	Language						
What is your relationship to the children needing care?							
	□Foster Parent						
Are you: Employed? □Yes □No If Yes: Name of er	mployerZip Code						
In school/training? □Yes □No If Yes: Name of so	chool or programZip Code						
List Hours of Need Each Day: Your actual paid employment hours ea							
Sun to / Mon to / Tue to /	/ Wed to / Thur to / Fri to / Sat to						
Characteristics: Please ☑ if you are: ☐ Looking for work ☐	Incapacitated □Homeless □Seasonal/Migrant Worker						
☐ Is this a CPS/At Risk Referral? If Yes Atta	ch Referring Agency Information						
Signature:	Date:						
2. SECOND PARENT/GUARDIAN INF	ORMATION (only if this is a two parent household)						
Name of Parent:							
Email Address:							
Race/Ethnicity:	Parent Date of Birth						
Language:							
What is your relationship to the children needing care?							
☐ Mother ☐ Father ☐ Grandparent ☐ Guardian							
	employer Zip Code						
In school/training? □Yes □No If Yes: Name of s	school or programZip Code						
List Hours of Need Each Day: Your actual paid employment hours ea	ach day or school hours						
Sun to / Mon to / Tue to /	/ Wed to / Thur to / Fri to / Sat to						
Characteristics: Please ☑ if you are: ☐ Looking for wor	rk □Incapacitated □Seasonal/Migrant Worker						
3 P	REFERENCES						
5.1	NEI ENEROLO						
AREA PREFERENCE (If more than one, please indicate 1st 2nd 3rd cho	ice)						
Ukiah & Surrounding AreasWillits	& Surrounding AreasCoast						
Willia							

NAME				1	<i>y</i>	house	,			7
			1	Schedule of Care Needed Please ☑						
1.		DATE OF BIRTH	RACE/ ETHNICITY	CHILDCARE NEEDED		FULL TIME	PART TIME	EVENING	OVERNIGHT	WEEKEND
1.				YES	NO					
2.										
3.										
4.										
5.										
		5. ADDITIO	NAL COMM	1ENTS	5				<u>'</u>	
	6. IN	ICOME & OTHER I	MEANS TES	TED P	ROGR	AMS				
Have you ever received cash aid th	rough the H	Health & Human S	Services Age	ency wi	ithin t	he pas	t 24 m	onths?		
	□No									
If yes, what was the last month and ye										
Was this for the child (ren) ONLY		or BOTH	Parent and C	Child (re	en)					
If you are receiving or enrolled in a	ny of the fo	llowing means te	sted program	ns, ple	ease o	heck [ox below:		
□ Medi-Cal □ Cal Fresh □ Califor	nia Food Ass	istance Program	☐The Feder	al Food	l Distri	bution	Program	on Indian F	Reservations	
□WIC (Woman's, Infants, and Children	n Nutrition Pr	rogram) □Head S	Start □Ear	lv Head	Start					
		Ond D		.,	. • • • • •					
1 st Parent/Guardian		2 nd Parent/Gu	ardian							
Gross Employment Wages or Salary:	\$	Gross Employ	ment Wages	or Sala	ry	\$		PLEASE	E NOTE:	
Gross Employment Wages or Salary: \$ x x 52 ÷ 12 =		Gross Employ \$	/ment Wages x x x Hours per week	or Sala 52 ÷ 12	ry	\$		Comple	etion of this ap	
Gross Employment Wages or Salary: $x = x \times $	\$	Gross Employ \$ Rate Spousal/Chile	vment Wages x x x Hours per week d Support reco	or Sala 52 ÷ 12 eived	ry	\$		Comple is NOT		r services.
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Gross Employment Wages or Salary: \$ x x x 52 ÷ 12 = Spousal/Child Support received Spousal/Child Support paid	\$	Gross Employ \$ Spousal/Chile Spousal/Chile	ment Wages X X X Hours per week d Support record Support pain	or Sala 52 ÷ 12 eived	ry	\$ \$		Comple is NOT Your pla	etion of this ap a guarantee fo acement on th ased on an elig	r services. e eligibility
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