



LAKE COUNTY ELIGIBILITY LIST

Application for Alternative Payment Childcare Services

PLEASE RETURN THIS FORM TO:

NCO/Rural Communities Childcare 850 Lakeport Blvd Lakeport, CA 95453

> 707-263-7513 FAX 707-263-4688

1. FIRST PARENT/GUARDIAN INFOR	RMATION					
Name of Parent	Home Phone					
Mailing Address	Work Phone					
Physical Address	Cell Phone					
City Zip Code	Parent Date of Birth					
Email Address:						
How did you hear about our services?	Language					
What is your relationship to the children needing care?						
☐Mother ☐Father ☐Grandparent ☐Guardian ☐Foster Parent						
Are you: Employed? □Yes □No If Yes: Name of employer	Zip Code					
In school/training? □Yes □No If Yes: Name of school or program						
List Hours of Need Each Day: Your actual paid employment hours each day or school hou						
Sun to / Mon to / Tue to / Wed to /						
Characteristics: Please ☑ if you are: ☐Looking for work ☐Incapacitated ☐F						
☐ Is this a CPS/At Risk Referral? If Yes Attach Referring Agency Ir	nformation					
Signature:	Date:					
2. SECOND PARENT/GUARDIAN INFORMATION (only if t	his is a two parent household)					
Name of Paragraph	Discourse					
	Phone					
	Phone t Date of Birth					
Race/Ethnicity: Parent Language:	t Date of Birth					
What is your relationship to the children needing care?						
□ Mother □ Father □ Grandparent □ Guardian □ Foster Parent						
	Zip Code					
	Zip Gode					
List Hours of Need Each Day: Your actual paid employment hours each day or school hou						
Sunto/ Monto/ Tueto/ Wedto/	Thur to / Fri to / Sat to					
Characteristics: Please ☑ if you are: ☐ Looking for work ☐ Incapacit	ated Seasonal/Migrant Worker					
3. PREFERENCES						
AREA PREFERENCE (If more than one, please indica Lakeport Lower LakeClearlake AreaKelseyvilleUpper LakeNice/	ate 1 st 2nd 3 rd choice) Clearlake OaksMiddletown 'LucerneCobb					

		IFORMATION (for e								
			RACE/ ETHNICITY	Schedule of Care Needed Please ✓						
NAME		DATE OF BIRTH		CHILDCARE NEEDED		FULL TIME	PART TIME	EVENING	OVERNIGHT	WEEKEND
				YES	NO				ļ	
1.										
2.										
3.										
4.										
5.										
		5. ADDITIO	NAL COMM	MENTS	<u> </u>	ı	1	ı	1	1
	6. II	NCOME & OTHER	MEANS TES	TED P	ROGR	AMS				
Have you ever received cash aid t	hrough the	Health & Human S	Services Age	ency wi	ithin t	he pas	st 24 m	onths?		
□Yes	□No									
□103										
If yes, what was the last month and ye	ear you recei	ved a check?		Case	e Num	ber				
If yes, what was the last month and ye	ſ	or BOTH	Parent and 0	Child (re	en)					_
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