



Date of Application: \_\_\_\_\_

3737 Martin Luther King Jr. Blvd., Suite 201 Lynwood, CA 90262 (310) 638-8108 Fax (310) 638-9554

## ELIGIBILITY LIST FOR DREW CENTERS

How did you hear about our program: \_\_\_\_\_

PARENT/GUARDIAN # 1 INFORMATION (Must provide information on all adults in the household)		
Last name:	First name:	Primary language:
Street address:	City:	Zip Code:
Home phone:	Work phone:	Cell phone:
Are you currently receiving cash aid? <input type="checkbox"/> Yes <input type="checkbox"/> No    If NO, have you received cash aid within the last two years? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES last date of cash aid payment: ____/____/____		

REASON FOR NEEDING CHILD CARE (Check all that apply)		
<input type="checkbox"/> Working (Employer's Name/Zip Code: ) _____	<input type="checkbox"/> Looking for Work	<input type="checkbox"/> Homeless/Seeking housing
<input type="checkbox"/> Attending School or Job Training (Name of School/Zip Code: ) _____	<input type="checkbox"/> Part-day preschool experience for child ONLY	<input type="checkbox"/> Migrant Worker
<input type="checkbox"/> Medically Incapacitated/Disabled		

INCOME (Write total dollars, before taxes and deductions, for each source of income)					
MONTHLY INCOME	SOURCE	MONTHLY INCOME	SOURCE	MONTHLY INCOME	SOURCE
\$	Wages/salaries or income from self-employment	\$	Spousal Support	\$	Food Stamps
\$	Social Security Benefits	\$	State Disability	\$	Unemployment benefits
\$	Worker's Compensation	\$	Child Support	\$	Pensions/Annuities
\$	State Supplemental income	\$	Adoption Subsidies	\$	Cash Aid (from County)
\$	Other:	\$	If you <u>pay out</u> child support, how much is it per month?		

PARENT/GUARDIAN # 2 INFORMATION		
Last name:	First name:	Primary language:
Home phone:	Work phone:	Cell phone:
Are you currently receiving cash aid? <input type="checkbox"/> Yes <input type="checkbox"/> No    If NO, have you received cash aid within the last two years? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES last date of cash aid payment: ____/____/____		

REASON FOR NEEDING CHILD CARE (Check all that apply)		
<input type="checkbox"/> Working (Employer's Name/Zip Code: ) _____	<input type="checkbox"/> Looking for Work	<input type="checkbox"/> Homeless/Seeking housing
<input type="checkbox"/> Attending School or Job Training (Name of School/Zip Code: ) _____	<input type="checkbox"/> Part-day preschool experience for child ONLY	<input type="checkbox"/> Migrant Worker
<input type="checkbox"/> Medically Incapacitated/Disabled		

INCOME (Write total dollars, before taxes and deductions, for each source of income)					
MONTHLY INCOME	SOURCE	MONTHLY INCOME	SOURCE	MONTHLY INCOME	SOURCE
\$	Wages/salaries or income from self-employment	\$	Spousal Support	\$	Food Stamps
\$	Social Security Benefits	\$	State Disability	\$	Unemployment benefits
\$	Worker's Compensation	\$	Child Support	\$	Pensions/Annuities
\$	State Supplemental income	\$	Adoption Subsidies	\$	Cash Aid (from County)
\$	Other:	\$	If you <u>pay out</u> child support, how much is it per month?		

CHILDREN LIVING AT HOME (All children in the household under 18 or under age 22 if disabled)							
#1. First Name _____ Last Name _____				#2. First Name _____ Last Name _____			
Birth date: _____		Gender: M F	Preferred Drew Center for care: _____	Birth date: _____		Gender: M F	Preferred Drew Center for care: _____
Care Needed: (Check all schedules that apply) <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends <input type="checkbox"/> NONE				Care Needed: (Check all schedules that apply) <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends <input type="checkbox"/> NONE			
Child School Name / Grade: _____			District: _____	Child School Name / Grade: _____			District: _____
IF CHILD IS IN CHILD PROTECTIVE SERVICES PLEASE COMPLETE HERE				IF CHILD IS IN CHILD PROTECTIVE SERVICES PLEASE COMPLETE HERE			
Foster Care Payments		Social Worker's Name	Contact Number	Case Number		Case Number	
\$ _____		_____	_____	_____		_____	
At Risk of Abuse, Neglect or Exploitation? (Must have a referral) <input type="checkbox"/> Yes <input type="checkbox"/> No			List related siblings in the same household: _____	At Risk of Abuse, Neglect or Exploitation? (Must have a referral) <input type="checkbox"/> Yes <input type="checkbox"/> No			List related siblings in the same household: _____
Referred by: _____				Referred by: _____			
"Parents" Relationship To This Child: <input type="checkbox"/> Biological <input type="checkbox"/> Foster <input type="checkbox"/> Guardian <input type="checkbox"/> Adoptive <input type="checkbox"/> Other:				"Parents" Relationship To This Child: <input type="checkbox"/> Biological <input type="checkbox"/> Foster <input type="checkbox"/> Guardian <input type="checkbox"/> Adoptive <input type="checkbox"/> Other:			

#3. First Name _____ Last Name _____				#4. First Name _____ Last Name _____			
Birth date: _____		Gender: M F	Preferred Drew Center for care: _____	Birth date: _____		Gender: M F	Preferred Drew Center for care: _____
Care Needed: (Check all schedules that apply) <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends <input type="checkbox"/> NONE				Care Needed: (Check all schedules that apply) <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends <input type="checkbox"/> NONE			
Child School Name / Grade: _____			District: _____	Child School Name / Grade: _____			District: _____
IF CHILD IS IN CHILD PROTECTIVE SERVICES PLEASE COMPLETE HERE				IF CHILD IS IN CHILD PROTECTIVE SERVICES PLEASE COMPLETE HERE			
Foster Care Payments		Social Worker's Name	Contact Number	Case Number		Case Number	
\$ _____		_____	_____	_____		_____	
At Risk of Abuse, Neglect or Exploitation? (Must have a referral) <input type="checkbox"/> Yes <input type="checkbox"/> No			List related siblings in the same household: _____	At Risk of Abuse, Neglect or Exploitation? (Must have a referral) <input type="checkbox"/> Yes <input type="checkbox"/> No			List related siblings in the same household: _____
Referred by: _____				Referred by: _____			
"Parents" Relationship To This Child: <input type="checkbox"/> Biological <input type="checkbox"/> Foster <input type="checkbox"/> Guardian <input type="checkbox"/> Adoptive <input type="checkbox"/> Other:				"Parents" Relationship To This Child: <input type="checkbox"/> Biological <input type="checkbox"/> Foster <input type="checkbox"/> Guardian <input type="checkbox"/> Adoptive <input type="checkbox"/> Other:			

CHILDREN WITH SPECIAL NEEDS, DISABILITIES OR MEDICAL CONDITIONS				
Check all that apply for each child listed above	CHILD # 1	CHILD # 2	CHILD # 3	CHILD # 4
Child has Individual Family Services Plan (IFSP) (age 0-3)				
Child has an Individual Education Plan (IEP) ages 3 and older				
Receives Early Start/Regional Center services				
Receives services from local school district (special education)				
Developmental delays (cognitive, autism, Down syndrome, etc.)				
Developmental delays (physical motor)				
Social/Emotional delays or behavior				
Physical disability (cerebral palsy, spinal bifida, orthopedic limitations, etc.)				
Health/medical (asthma, diabetes, other _____)				
Speech/language/communication				
Hearing/vision				