State Department of Education
Child Development Division
CD-9607 (Rev 09/05)

To be completed by parent or guardian and updated at recertification and as changes occurs.

Emergency and Identification Information

I. Family Information

Child's name (Last, First, Middle): _____ Birth Date: _____

Mother's name: _____

Father's name: _____

Child's Address: _____ Phone: _____

Mother's business address: _____ Phone: _____

Father's business address: _____ Phone: _____

II. Names of Persons Authorized to Take Child from the Facility (This child will not be allowed to leave with any other person without written authorization from parent or guardian.)

Name	Telephone	Relationship

III. Additional Persons Who May Be Called in an Emergency to Take Child from the Facility

Name	Address	Telephone	Relationship

IV. Physician to Be Called in an Emergency

Name _____ Telephone _____

Address _____

V. Medi-Cal Number _____ **Medical Insurance** _____

Insurance Number _____

VI. Allergies or Other Medical Limitations _____

_____

VII. Permission for Medical Treatment Administrative procedures vary among medical personnel and medical facilities with regard to provision of medical care for a child in the absence of the parent. The exact procedure required by the physician or hospital to be used in emergencies should be verified in advance.

In case of an accident or an emergency, I authorize a staff member of the child development agency to take my child to the above-named physician or to the nearest emergency hospital for such emergency treatment and measures as are deemed necessary for the safety and protection of the child, at my expense.

Signature _____ Date _____
Parent or Guardian

Pathways LA

Attn: _____

FAMILY SIZE INFORMATION

Please list the names of all the **adults** that are currently residing in your household:

Names:	*Relationship to you:*	*Relationship to your children:*
1. _____	_____Self_____	_____Parent_____
2. _____	_____	_____
3. _____	_____	_____

Please list the names of all the **children** that are currently residing in your household:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

I declare that I am (please mark one):

☐ A single-parent household.

☐ A two-parent household: Second Parent's Name _____

ALIMONY AND CHILD SUPPORT AFFIDAVIT

Alimony:

☐ I am currently receiving $ _____ per month for alimony.
☐ I am **NOT** receiving any alimony.

Child Support:

☐ I am currently receiving $ _____ per month for child support.
☐ I am **NOT** receiving any child support.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information in this statement of facts is true, correct, and complete.

Name: _____ Email Address:_____

Signature: _____ Date: _____

Pathways LA

FAMILY NEEDS ASSESSMENT – CDE SUBSIDIZED PROGRAMS

Parent Name: _____

The areas listed below are common family concerns. Check [ ] **YES** if you would like information on any of these subjects. Check [ ] **NO** if you have no needs or are not interested at this time:

Education	☐ Yes	☐ No	Teen Assistance	☐ Yes	☐ No
Health Services (Medical)	☐ Yes	☐ No	Legal Services	☐ Yes	☐ No
Family Counseling	☐ Yes	☐ No	Financial Assistance	☐ Yes	☐ No
Domestic Violence	☐ Yes	☐ No	Housing	☐ Yes	☐ No
Adult/Child Abuse	☐ Yes	☐ No	Special Needs	☐ Yes	☐ No
Emergency Assistance	☐ Yes	☐ No	General Information	☐ Yes	☐ No

Is your family experiencing homelessness? _____

Do you need resources to help find permanent housing? _____

Are you receiving services from any other social services agencies? _____

_____

Do you feel supported by services provided by Pathways LA and other agencies? _____

_____

If not, what is needed to help support you and your family? _____

_____

What have you been able to achieve by having childcare services with Pathways LA? _____

_____

What kinds of things does your family like to do together? _____

_____

What are your family strengths? _____

What areas can be strengthened? _____

Is English your child's first language? ☐ Yes ☐ No, if no, what is? _____

Will you advise your childcare provider of your language preference? ☐ Yes ☐ No

What do you personally want to achieve in the coming year? _____

_____

Parent signature: _____ Date: _____

****

STAFF USE ONLY:

Follow-up needed? ☐ Yes ☐ No Referrals given: _____

Observations: _____

Pathways Representative Initials: _____

Parent Letter
85% Exit Threshold Notification

Date: _____

Name: _____
Address: _____
_____

Dear Parent,

Per the California Department of Social Services (CDSS) directives, at initial certification you are determined income eligible for services if your family's adjusted monthly income remains at or below 85 percent of the State Median Income, adjusted for family size. You will remain income eligible for services throughout the current certification period and at recertification until your adjusted monthly income exceeds 85 percent of the most recent SMI, adjusted for family size. In the table below locate your family size to determine the maximum family monthly income you can earn to remain eligible for services. You have an obligation to report increases in income that exceed the 85 percent threshold for ongoing income eligibility, and at that time your ongoing eligibility for services shall be redetermined. By signing below you acknowledge this policy and documentation was reviewed and that you understand the implications.

Family Size	Family Monthly Income	Family Annual Income
1-2	$6,008	$72,096
3	$6,842	$82,104
4	$7,941	$95,292
5	$9,211	$110,532
6	$10,482	$125,784
7	$10,720	$128,640
8	$10,958	$131,496
9	$11,196	$134,352
10	$11,435	$137,220
11	$11,673	$140,076
12	$11,911	$142,932

Table 1. Schedule of Income Ceilings (85 percent SMI) for Recertification Child Care and Development Programs

_____ _____
Signature Date

Pathways

Attn: _____

INCOME CALCULATION WORKSHEET

SECTION A: Total Monthly Countable Income

(To be completed by PARENT)

	Sources of Income	Parent A	Parent B
1	Gross Wages/Salary/Tips	$	$
2	Gross Income from self-employment less business expenses with the exception of wage draws		
3	Advances/Commissions/ Bonuses (If one-time only, prorate over a twelve month period.)	$	$
4	Allowances for housing or automobiles provided as part of compensation		
5	Public Cash Assistance (CalWORKs or TANF)	$	$
6	Disability		
7	Unemployment Compensation	$	$
8	Federal SSI / SSP	$	$
9	Worker's Compensation	$	$
10	Spousal Support received (including financial assistance for housing costs or car payments)	$	$
11	Child Support Received (including financial assistance for housing costs or car payments)	$	$
12	Survivor (i.e. SSA) and retirement benefits	$	$
13	Dividends, interest on bonds, income from estates or trusts, net rental income or royalties	$	$
14	Rent for room within family's residence	$	$
15	Portion of student grants or scholarships not identified for educational purposes as tuition, books, or supplies		
16	Foster Grants, payments or clothing allowance for children placed through child welfare services		
17	Financial assistance received for the care of a child living with an adult who is not the child's biological or adoptive parent	$	$
18	Veteran's pension	$	$
19	Pensions or annuities	$	$
20	Insurance or Court settlements for lost wages or punitive damages	$	$
21	Net proceeds from the sale of real property, stocks, or inherited property	$	$
22	Gambling or Lottery Earnings	$	$
23	Other (Do not include food stamps)	$	$
24	**Sub Total Gross Monthly Income**	$	$
25	Minus family fee/child care /child support paid for other children		
26	If Parent receives SSI/SSP income, all income is excluded. Therefore, Parent's Total Gross Monthly Income is $ 0.00. However, if any other individual (e.g. child) receives SSI/SSP, the SSI/SSP would be excluded from the Parent's Sub Total Gross Monthly Income. I declare that I am currently receiving SSI/SSP for _____.		
27	**Total Countable Monthly Income**		

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information in this statement of facts is true, correct, and complete. I will notify my Program Specialist within 5 days if there is any change in my income.

_____ _____

Signature of Parent Date

_____ _____

Signature of Agency Representative Date

Pathways LA

CHILD SCHOOL AND TRACK INFORMATION
____- ____ SCHOOL YEAR

Specialist:___

CASE NAME:

PLEASE FOLLOW THESE INSTRUCTIONS:

1. **List information for all school aged children receiving services.**
2. **Attach a copy of each child's current school calendar, bell schedule or online learning schedule.**
3. **Write your name and your Case Specialists name on every document you submit.**
4. **Remember that it is your responsibility to report all changes in school or school hours. Failure to do so may affect your provider's reimbursement.**

CHILD NAME: ______________________ GRADE: __________

SCHOOL NAME: ______________________ DISTRICT: __________

SCHOOL ADDRESS: ______________________

Child will participate (check one box): ☐Online ONLY ☐Online and Onsite (mixed schedule) ☐Onsite ONLY

BELL SCHEDULE: ______________________ EARLY RELEASE DAY: M T W TH F

Track (if applicable): ______________________ TIME RELEASED: __________

CHILD NAME: ______________________ GRADE: __________

SCHOOL NAME: ______________________ DISTRICT: __________

SCHOOL ADDRESS: ______________________

Child will participate (check one box): ☐Online ONLY ☐Online and Onsite (mixed schedule) ☐Onsite ONLY

BELL SCHEDULE: ______________________ EARLY RELEASE DAY: M T W TH F

Track (if applicable): ______________________ TIME RELEASED: __________

CHILD NAME: ______________________ GRADE: __________

SCHOOL NAME: ______________________ DISTRICT: __________

SCHOOL ADDRESS: ______________________

Child will participate (check one box): ☐Online ONLY ☐Online and Onsite (mixed schedule) ☐Onsite ONLY

BELL SCHEDULE: ______________________ EARLY RELEASE DAY: M T W TH F

Track (if applicable): ______________________ TIME RELEASED: __________

Pathways LA

Employment Information

To be completed by the **PARENT**

As a parent needing child care while employed:

(Parent initials)

_____ 1. I authorize Pathways to contact my employer and verify all information regarding my employment, including but not limited to my scheduled hours, rate of pay, pay period, potential for overtime, tips, or additional compensation.

_____ 2. I understand that it is my responsibility to inform Pathways of increases to my family's income that exceeds 85% of the State Median Income within 30 days. I can also voluntarily report changes which will result in a positive change to my service level, such as an increase in my work hours or decrease in income which will result in a reduction in my family fees.

_____ 3. I understand that I am responsible for providing Pathways with accurate documentation regarding my income. This includes, but is not limited to, pay stubs, letters from my employer, most recently signed and completed tax returns, quarterly estimated tax statements, or other records to support the reported income.

_____ 4. I understand that I must submit income information at my yearly recertification, during any update in my application, or at any time deemed necessary by Pathways.

_____ 5. In addition to my income from my employment, I am required to submit copies of documentation of all non-wage income (such as CalWORKs grant, work bonuses, child support, alimony, etc.)

_____6. I understand that my child care specialist will determine my eligible hours based on work hours verified and pay stubs submitted. If the hours reflected on my pay stubs do not coincide with a set schedule, and reflect variable work hours, I will be approved on a variable schedule. If I do not agree with decision, I may file an Appeal and will be required to submit supportive documentation to change the approved hours to a set schedule.

_____ 7. At certification, if I work a variable schedule, I will be required to submit three months' worth of complete paystubs in order to extend services for no less than 12 months. I understand that failure to submit complete income information will be grounds for termination of child care services.

_____ 8. Child care services provided for variable schedules will be reimbursed based on actual hours of care used as reflected on the attendance sheet submitted by your provider. Variable schedule needs are not eligible for holidays, absences, or best interest days.

I understand that my failure to comply with the rules of the program or terms of this employment agreement may result in the immediate termination of child care services in which case I become solely responsible for paying for all of my child care costs. In addition, I understand that I may not alter the terms of this agreement without prior written approval from Pathways and that Pathways reserves the right to request additional documentation regarding my employment.

I have read and fully understand and agree with the terms of these employment policies.

Parent Name: _____ Date: _____

Parent Signature: _____

Pathways LA

Employment Information

To be completed by the **PARENT**

Authorization for Release of Employment Information

I, _____ (Parent/Employee's Name), hereby authorize Pathways and its representatives to verify my employment for purposes of determining my eligibility for the Child Care Payment and Assistance Programs. This includes, but is not limited to, my start date, work schedule, rate of pay, and employment location.

For employee identification purposes, I am providing the following information

Social Security Number: _____-____-_____
*Please provide if required for identification

Date of birth: _____/_____/_____

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

**Parent: Please ensure your name is legible and that you sign and date the form. Incomplete or illegible forms will not be valid.*

Pathways LA

Employment Information

To be completed by the **PARENT**

Parent Name: _____

Company/Employer Name: _____ Employer Phone: _____

Company/Employer Address: _____ City: _____ Zip: _____

Supervisor Name: _____ Supervisor Title: _____

What is your position? _____ When did you begin work? _____

Business Hours of Operation: _____

Do you work at address above: ☐ Yes ☐ No (indicate actual location): _____

Is this a permanent job? ☐ Yes ☐ No (indicate end date: _____)

You are paid: ☐ via Personal Check ☐ via Payroll Check

☐ in cash (please submit a statement from your employer indicating your job duties and work responsibilities.)

Payday is: ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly

Your Wages: $_____ per _____ (hour, week, day, month or, year)

Do you receive: Tips? ☐ Yes ☐ No Commission? ☐ Yes ☐ No

Potential for overtime? ☐ Yes ☐ No Other Compensation? ☐ Yes ☐ No

Indicate the total income received for the last month: $ _____ *(If yes, please specify: _____)*

Schedule:

Length of Lunch period: ☐ 30 minutes ☐ 60 minutes ☐ Other: _____ Is Lunch paid? ☐ Yes ☐ No

☐ **1.** Your work schedule is set (the same every week) as follows:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Start	am / pm	am / pm	am / pm	am / pm	am / pm	am / pm	am / pm
End	am / pm	am / pm	am / pm	am / pm	am / pm	am / pm	am / pm

☐ **2.** Your work schedule is variable (changes from week to week.)

☐ Days Vary: indicate max days _____ ☐ Hours Vary: indicate max hours per week _____

If applicable: please indicate the range of days and hours of the variable schedule:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Start	am / pm	am / pm	am / pm	am / pm	am / pm	am / pm	am / pm
End	am / pm	am / pm	am / pm	am / pm	am / pm	am / pm	am / pm

Please check box if the hours are 24 hours per day, 7 days per week: ☐ Yes ☐ No

☐ **3.** Rotating schedule**.** Please specify: _____

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained on this page is true and correct to the best of my knowledge.

Parent signature: _____ Date: _____

**All information provided is subject to verification by Pathways*

PATHWAYS OFFICE USE ONLY

Work Number Required: ☐ Yes ☐ No Verified: ☐ Yes ☐ No Initials: _____ Date: _____

Pathways LA

Request for Travel Time

Name:_____ Case Manager: _____

In order to assist us in assessing your child care needs, please indicate the following:

Title 5 18086(e)(1) – travel to and from the location at which services are provided and the place of employment, not to exceed half of the daily hours authorized for employment to a maximum of four hours per day.

Title 5 18087(k)(1) – travel to and from the location at which services are provided and the training location, not to exceed half of the weekly hours authorized for training to a maximum of four hours per day.

Your provider's address: _____
street address

_____
city zip code

(if more than one, please indicate): _____
street address

_____
city zip code

Your final destination: _____
street address

_____
city zip code

Your method of transportation (circle):

☐Car ☐Bus ☐Train ☐Walk ☐other: _____

The amount of travel time you are requesting *from provider to activity* way: _____ minutes

The amount of travel time you are requesting *from activity to provider* way: _____ minutes

Please explain why you are requesting this amount of transportation:

_____

_____

I declare under penalty of perjury under the laws of the United States of America and the State of California at the information in this statement of facts is true, correct, and complete.

Signature: _____ Date: _____

For Office Use Only:

Travel time was verified via: ____Google Maps ____ Metro.net ____ Other: _____

Amount of travel time granted: _____ minutes ***to*** activity _____ minutes ***from*** activity _____

I attest this travel time is reasonable and therefore approve it: Staff initials: _____ Date: _____

PARENT HANDBOOK RECEIPT

INTRODUCTION

The Pathways LA Parent Handbook (7/2019 Edition) contains program descriptions, and eligibility and participation requirements. Review the Handbook in its entirety and contact your Program Specialist with any questions. Sign this acknowledgement of receipt, and submit it via email at **childcare@pathwaysla.org**, electronically using the Family Portal, in person, or mail it to:

Pathways LA
Attn: CDE Division
3325 Wilshire Blvd, Ste 1100
Los Angeles, CA 90010

CONTACT

How may we contact you about your Pathways LA case and our programs? Check all that apply.

☐ Phone: (_____) _____ - _____ ☐ Text: (_____) _____ - _____

☐ Email: _____

PARTICIPANT ACKNOWLEDGEMENT

By signing below, I acknowledge receipt of the Pathways LA Parent Handbook (7/2019 Edition). I agree to make myself familiar with its contents, pursue clarification of any questions I might have, and adhere to all the rules and regulations set forth. I specifically acknowledge understanding of the following policies, procedures, and/or disclosures:

_____ Confidentiality Pg 8
_____ Fraud Pg 10
_____ Types of Care Pg 16
_____ Unlimited Access to Child Pg 18
_____ Providers Are Ind. Contractors PG 19
_____ Changing Child Care Provider Pg 19
_____ 85% SMI Table Pg 33
_____ Notification of Changes Pg 34
_____ Recertification Procedure Pg 35
_____ Suspension of Services Pg 36
_____ Termination for Failure to Comply Pg 37
_____ Appeals and Fair Hearings Pg 38
_____ Inconsistent Use of Service Pg 43
_____ Non-Use of Service Pg 44
_____ Family Fee Pg 47
_____ Co-Payment Pg 48
_____ Child Care for School-Aged Children Pg 48
_____ Other Fees Pg 50

I further understand that I will be notified by Pathways LA of any policy updates in writing, and that I have an obligation to review those policies when they are provided to me to continue my participation in a Pathways LA program.

Parent/Caregiver Name (Print)	Parent/Caregiver Signature	Date

OFFICE USE ONLY Received on: _____/_____/_____ Via: ☐ Mail ☐ Fax ☐ Email Verified on: _____/_____/_____
Case Specialist Name (Print): _____ Case Specialist Signature: _____

You can always access the Pathways LA Parent Handbook at any time online at:
https://pathwaysla.org/wp-content/uploads/2020/07/PTHandbook_OnlineVersion_2019.pdf