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

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

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

Attn: _____

Seeking Employment Policies

If the basis of child care need is to seek employment: Each parent is eligible for a period no less than 12 months. Approved child care hours for job seek activities will not exceed 5 days per week (Monday through Friday) and must be less than 30 hours per week.

As a parent needing child care in order to seek employment:

(Parent Initials)

⇩

_____ 1. I understand that I may only use child care services during this certification period for purposes of seeking employment, filling out job applications, attending job interviews, and conducting other job search related activities which are reasonable and necessary for securing employment.

_____ 2. I can voluntarily report changes that will result in an increase in my child care services level.

_____ 3. I understand that child care can be approved on no more than five days per week (Monday through Friday) and for less than 30 hours per week.

_____ 4. I also understand that I may not exceed the certification period nor the days and hours of child care services specified in my Notice of Action and Parent Agreement.

_____ 5. If I am enrolled in the GAIN program, I understand that my GAIN worker may be required to approve any and all activities, including seeking employment.

_____ 6. I further understand that I may not alter the terms of this agreement without prior written approval from Pathways LA.

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

_____	_____	_____
Parent Name	Parent Signature	Date

Pathways LA

Attn: _____

Seeking Employment Declaration

Parent Name: _____

You have requested child care while you seek employment. Child care services while seeking employment are limited to no more than five days per week (Monday through Friday) and less than 30 hours per week for a period no less than 12 months. Your Program Specialist will review your request and assign hours as applicable. Please answer the questions below to describe your plan to secure, change, or increase employment.

1. **Please indicate the start date of your seeking employment activity:** _____
2. **How will you be doing your job search? (Ex: searching websites, meeting with employers):**_____

   _____
3. **What position or type of position will you be seeking? (Ex: medical assistant, retail, and so forth):** _____
4. **Where will you be looking for employment? (Ex: using computers at the library, community colleges and/or job fairs):**_____

   _____

Please indicate when services will be necessary (days and hours):

	From:	To:
Monday	am/pm	am/pm
Tuesday	am/pm	am/pm
Wednesday	am/pm	am/pm
Thursday	am/pm	am/pm
Friday	am/pm	am/pm

☐ Please check this box if your seeking employment hours will be on a variable schedule Monday through Friday.

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.

Signature: _____ **Date**: _____