

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

Developing innovative programs to serve the special needs of young children and their families.

3325 Wilshire Blvd Ste 1100 • Los Angeles, CA 90010

Phone: (213) 427-2700 • Fax: (213) 427-2701

FAMILY SIZE INFORMATION

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

Names:

1. _____
2. _____
3. _____

Relationship to you:

_____ Self _____

Relationship to your children:

_____ Parent _____

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

1. _____
2. _____
3. _____

4. _____
5. _____
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: _____

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

CHILD SCHOOL AND TRACK INFORMATION

____ - ____ SCHOOL YEAR

CASE NAME: _____

Specialist: _____

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 T H 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 T H 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 T H F
Track (if applicable): _____ **TIME RELEASED:** _____

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

Self-Employment Policies

As a parent needing child care for my self-employment:

(Parent initials)



- ____ 1. I authorize Pathways to verify all information regarding my self-employment, including but not limited to my scheduled hours, rate of pay, pay period, 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.
- ____ 4. I understand that I am responsible for providing Pathways with accurate documentation regarding my income. This includes, but is not limited to, pay stubs, list of clients and amounts paid, most recently signed and completed tax returns, quarterly estimated tax statements, or other records to support the reported income.
- ____ 5. 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.
- ____ 6. In addition to my income from my self-employment, I am required to submit copies of documentation of all non-wage income (such as CalWORKs grant, child support, alimony, etc.)
- ____ 7. I am required to submit a combination of documentation to establish my income eligibility including but not limited to, a letter from the source of income, copy of most recently signed and completed tax returns with a statement of current estimated income for tax purposes, and/or other business records, ledgers, receipts, business logs, etc.
- ____ 8. I am required to submit verification of my self-employment and Pathways has the right to verify all information submitted, such as appointment logs, client receipts, job logs, mileage logs, a list of clients with contact information, copy of business license, a workspace lease, a workspace rental agreement, etc.
- ____ 9. Pathways may contact my clients, review my bank statements, and/or confirm information from my advertisement or web site in order to verify my income and need for child care services.

I understand that my failure to comply with the rules of the program or terms of this self-employment agreement may result in the immediate denial 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 self-employment.

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

Parent Name: _____ Date: _____

Parent Signature: _____

Self-Employment Policies

Parent Name: _____ Type of Business (please be specific): _____

Employment Start Date: _____

Employment Address: _____, if address varies, mark here ☐

City: _____ Zip Code: _____ Phone: _____

Describe the nature of the employment (please be specific):

Please provide an estimate of the days and hours you work per week:

My work days and hours vary.

Days: I work anywhere from _____ (minimum) to _____ (maximum) days per week.**Hours:** I work anywhere from _____ (minimum) to _____ (maximum) hours per week.

My work days and hours are set:

	From:	To:
Sunday	am/pm	am/pm
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
Saturday	am/pm	am/pm

I understand that I will be required to submit additional documentation to verify my self-employment. I authorize Pathways to obtain the information deemed necessary to support the hours and days regarding my self-employment including, but not limited to, contacting my clients and/or my lessor.

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: _____

For office use only:

[] Approved [] Denied

Supporting Documentation (mark all that apply)

☐ Appointment Logs
☐ Client Receipts
☐ Job Logs
☐ Mileage Logs

☐ Client Contact List (verified on _____)
☐ Business License
☐ Workspace Lease (verified on _____)
☐ Workspace Rental Agreement
(verified on _____)

I attest that the necessary information was collected, reviewed, and verified. The days/hours requested per week are reasonable based on the documentation provided. The criteria set forth by CDE for self-employment have been met.

Program Specialist: _____ Date: _____ Program Manager: _____



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