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

Attn: _____

STUDENT FAMILIES POLICIES

Student parents can receive child care for a limited period during the time they are in school and/or attending a training institution enrolled in a vocational training leading directly to a recognized trade, paraprofessional, or profession. Approved child care hours will be based upon the current training schedule. Parents must submit verification of training *before* child care hours can be approved.

Effective 7/1/08, child care services for students are limited to a maximum of six years from the date a parent began receiving child care services as a student or 24 units after the completion of a Bachelor's degree, whichever occurs first. In order to continue receiving child care services as a student, student parents must also demonstrate that they are making satisfactory progress and meet all other program requirements.

As a parent requesting child care services for school/training, I understand that:

(Parent Initials)

⇩

_____ 1. I must submit a signed training verification form with the registrar's signature or official stamp to verify enrollment and school hours. Proof of school registration may be acceptable for a limited time, however, I must submit a signed and stamped training verification by the indicated due date. Training verifications will not be accepted if:

- they have been altered or do not appear valid
- time and days of the enrolled classes are not filled out completely and properly
- I have not signed the form, or the form has not been signed and/or stamped by the registrar of the college or by the program director of the training institution
- the closing date of the semester/term is not clearly stated on the training verification.

_____ 2. I may not exceed the use of child care during the certification period nor may I exceed the specified days and hours stated on the Notice of Action and the certificate for child care services without prior approval from Pathways.

_____ 3. Child care for school hours is granted for a maximum of six years from my initial approval of child care services as a student (beginning 7/1/08) or a maximum of 24 units or its equivalent after receiving a Bachelor's degree, whichever comes first. Time will not be deducted for periods for which I receive child care services for other reasons such as employment, or periods of ineligibility for child care.

_____ 4. I am responsible for submitting grades as proof that I am making satisfactory progress toward my professional/vocational objective during my recertification period which will occur no less

Pathways

than 12 months from my certification date. Pathways may require an official copy of my progress report to be sent directly and/or verify any information that is submitted

_____ 5. Satisfactory progress is defined as a 2.0 Grade Point Average or better per term in a graded program or pass the requirements in at least 50% of the classes in a non-graded program. If I fall below this standard, I will be placed on probation for no less than 12 months following my recertification. If after the probationary period my progress is still unsatisfactory, my child care services will be terminated. In addition, I will not be eligible for child care services while training for 6 months from the date of termination.

_____ 6. Pathways will not approve child care services for the same course twice (repeated courses) due to failure or unsatisfactory grade.

_____ 7. I must report all types of financial aid provided to me by the college (i.e. Pell grants, work study programs, etc.) If I am an EOP student, I must also report any and all information regarding veteran's benefits, unemployment insurance, or part-time jobs.

_____ 8. I may request additional hours of child care to study. I am eligible for two hours per week per academic unit. I will not be given study time for non-academic courses.

_____ 9. For on-line or televised instructional courses that are unit bearing classes, I will be granted one hour a week for each unit as class time. I will need to submit a copy of the syllabus or other class documentation for all on-line courses.

_____ 10. I understand that the accreditation body of the training institution shall be among those recognized by the United States Department of Education.

This is to verify that I have a received a copy of the Student Policy and I have been informed of my obligations as a student parent.

Parent Signature: _____ Date: _____

OFFICE USE ONLY

Progress/GPA: _____

Date Child Care for Training Began: _____

Date Child Care for Training Will Expire: _____

Notes: _____

Specialist Signature: _____

CALIFORNIA DEPARTMENT OF EDUCATION
CHILD DEVELOPMENT DIVISION
Form CD-9605, (Revised: 02/04)

NOTE: When applicable, this form is to be completed and used with form, CD-9600.

TRAINING VERIFICATION - PARENT OR CARETAKER ATTENDING SCHOOL OR RECEIVING TRAINING

Please print or type information.

DATE

INSTRUCTIONS

Determining eligibility for child development services requires that the parent or caretaker do the following:

1. Complete all information requested.
2. When completed, take this form to the school or organization where the training or education will be received.
3. Request that the registrar (or his/her designee) verify the training plan as described by signing and stamping this form.
4. Return this form within two weeks to the agency that will provide the child development services.

AGENCY

PARENT OR CARETAKER'S NAME (last, first, middle) | TELEPHONE NO. ( )

STREET ADDRESS | CITY | ZIP CODE

TRAINING/EDUCATION INFORMATION

NAME OF SCHOOL OR ORGANIZATION WHERE TRAINING/EDUCATION IS RECEIVED | TELEPHONE NO. ( )

STREET ADDRESS | CITY | ZIP CODE

DATE THIS TERM BEGAN | DATE THIS TERM ENDS | ANTICIPATED COMPLETION DATE FOR TRAINING/EDUCATION

PROFESSIONAL OR VOCATIONAL GOALS

CLASS SCHEDULE (if applicable)

	DAY	TIME	ROOM NO.	COURSE NAME	UNITS
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

SIGNATURE OF PARENT OR CARETAKER | DATE

SIGNATURE AND STAMP OF REGISTRAR OF SCHOOL/ORGANIZATION | DATE

Pathways

Request for Study Time

Parent Name: _____ Case Number: _____

Semester/Quarter Start Date: _____
Semester/Quarter End Date: _____
Total # of units enrolled: _____

Parents in an approved training activity are eligible to receive child care services for study time. If you choose to request study time hours please indicate below the day/s and time that you are requesting.

According to program regulations, Title 5 18087(k)(2), study time, including study time for on-line and televised instructional classes, may be requested for up to two hours per week per academic unit in which the parent is enrolled.

Study time must be approved in writing by a Program Specialist. Hours will be approved based on reasonability of schedule requested, up to the maximum allowed.

I, _____ am requesting study time during the following periods:

	DAY	START TIME	END TIME
1.			
2.			
3.			
4.			
5.			
6.			

☐ Please check this box if your study time hours will be on a variable schedule.

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

3325 Wilshire Blvd Ste 1100 ● Los Angeles, CA 90010 ● Phone: 213-427-2700 ● Fax: 213-427-2701

Pathways

Request for Travel Time

Name: _____ Case Number: _____

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