FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

APPLICATION FOR NEW APPLICANTS ONLY

Application Deadline: September 20, 2016

I WORK AT A: *(Please check all that apply)*

- ❑ Licensed Family Child Care Home in a CDE/EESD funded FCC Network
  - ❑ Children's Home Society ❑ Chicano Federation
- ❑ Licensed CDE/EESD State-Funded Classroom.

EMPLOYMENT REQUIREMENT *(to be completed by AB212 Participant)*

I, _____, understand that I must be working in a CDE/EESD funded
(Print full name)
classroom in order to earn a stipend from AB212 CARES. If it is determined that my site/classroom is not CDE/EESD funded or I stop working in a qualified program, I will not be eligible for a stipend and my participation in AB212 CARES will end.

_____	_____	(____)_____
Participant Signature	*Date*	*Employer telephone #*

Please allow 4 weeks for AB 212 CARES to process your application. If you are eligible to participate you will receive an acceptance letter and information on how to access our forms online. If you are not eligible to participate, you will receive a denial letter and information on how to appeal. **Incomplete applications (missing information and/or documentation) will be returned. Application should be in the CARES office by deadline; no postmarked applications will be accepted.**

Submit your **complete** application with attached documentation in person, mail or fax to:

YMCA Childcare Resource Service/AB212 CARES
3333 Camino del Rio South #400
San Diego, CA 92108
Fax # 619.584.5328

Questions? Call the AB212 CARES toll-free line at 1.866.CARES SD (1.866.227.3773), send an email to caressd@ymca.org, or log on to www.crs.ymca.org for answers to frequently asked questions.

For Office Use Only Database Yr: _____ ID NUMBER: _____

Date Received: _____ Entered By: _____Reviewed By: _____ Date Reviewed: _____

Status of Application

- ❑ Application Approved Status Date: _____
- ❑ Application Incomplete: _____
- ❑ Application Denied: _____
- ❑ Notes: _____

AB212 CARES is administered by the YMCA Childcare Resource Service, a department of the YMCA of San Diego County, with funding from the California Department of Education through the County of San Diego.

SECTION 1: APPLICANT INFORMATION *Type or print legibly in ink.*

1. LAST NAME	2. FIRST NAME	3. MI	4. SOCIAL SECURITY NUMBER
			- -

5. WHAT YEAR DID YOU BEGIN WORKING IN THE CHILD CARE FIELD?

YEAR_____

HOW MANY YEARS HAVE YOU WORKED IN ANY OF THE FOLLOWING?

CENTER BASED_____

FAMILY CHILD CARE_____

6. HIGHEST LEVEL OF EDUCATION ATTAINED

- ❑ No formal schooling
- ❑ Less than a high school diploma
- ❑ High School Diploma or GED
- ❑ Some College
- ❑ AA in non-ECE/CD
- ❑ AA in ECE/CD
- ❑ BA in non-ECE/CD
- ❑ BA in ECE/CD
- ❑ Some graduate school
- ❑ Graduate degree in non-ECE/CD
- ❑ Graduate degree in ECE/CD

IF YOU HAVE A COLLEGE DEGREE, IS YOUR HIGHEST DEGREE FROM A FOREIGN COUNTRY?

❑ Yes ❑ No

7. DATE OF BIRTH

_____/_____ /_____
mm dd yy

8. WHAT CITY WERE YOU BORN IN?

9. GENDER

- ❑ Female
- ❑ Male

10. HOME ADDRESS	11. APT	12. CITY	13. ZIP

14. HOME PHONE	15. WORK PHONE	16. CELL PHONE
( ) _____- _____	( ) _____- _____	( ) _____- _____

17 E-MAIL ADDRESS *(required)*:	18. INTERNET ACCESS?	19. FAX NUMBER *(if applicable)*
	❑ Yes ❑ No	( ) _____- _____

RACE AND ETHNICITY *Please answer the following questions. This information is being collected for statistical purposes only. The categories match those of the 2000 United States Census.*

20a. WHAT IS YOUR PRIMARY LANGUAGE SPOKEN AT HOME?

_____

20b. WHAT LANGUAGE(S) DO YOU SPEAK WITH THE CHILDREN IN YOUR CARE?

_____ _____

21. WHICH RACE/ETHNICITY DO YOU MOST IDENTIFY YOURSELF WITH? *(Choose only one.)*

- ❑ American Indian/Alaskan Native
- ❑ Asian
- ❑ Black/African-American
- ❑ Hispanic/Latino
- ❑ Pacific Islander
- ❑ White
- ❑ Other:_____

MISCELLANEOUS INFORMATION

1. I CURRENTLY HOLD OR HAVE APPLIED FOR THE FOLLOWING CHILD DEVELOPMENT PERMIT THROUGH THE CALIFORNIA COMMISSION ON TEACHER CREDENTIALING: *(if applicable, please submit a copy of receipt or permit)*

- ❑ Assistant Teacher
- ❑ Associate Teacher
- ❑ Teacher
- ❑ Master Teacher
- ❑ Site Supervisor
- ❑ Program Director

2. I AM CURRENTLY ENROLLED OR WILL ENROLL IN COLLEGE: ❑ No ❑ Yes
(please complete the following information)

I AM ENROLLED OR WILL ENROLL AT_____**COLLEGE/UNIVERSITY.**
College name

I AM WORKING TOWARDS A _____ **DEGREE IN** _____***.**
Type of degree *Major*

Degree Major must be ECE/CD related, approved by AB212 CARES and include at least 24 units of Child Development.

SECTION 2: CHILD CARE PROGRAM INFORMATION

1. PLEASE CHECK ONE

- ❑ I own and operate a licensed family child care home that is part of a CDE/EESD funded FCC Network
- ❑ I am an employee at a licensed family child care home that is part of a CDE/EESD funded FCC Network
- ❑ I work in a CDE/EESD funded classroom.

2. NAME OF CHILDCARE PROGRAM (as listed on license)	**3. LICENSE NUMBER/EFFECTIVE DATE** ___/_____/_____ **LICENSE #**_____ *mm dd yyyy*
4. DIRECTOR OR FCC LICENSEE FULL NAME	**5. DIRECTOR OR FCC LICENSEE'S PHONE** **( )** _____**-**_____

6. ADDRESS	**7. CITY**	**8. ZIP CODE**	**9. SITE PHONE**
			( ) _____**-** _____

10. HOURS WORKED PER WEEK WITH CHILDREN AT CHILD CARE PROGRAM	**11. CURRENT JOB TITLE**	**12. ANNUAL GROSS INCOME (FROM CHILD CARE ONLY)**
_____	_____	**$**_____

13. NUMBER OF CHILDREN IN EACH AGE GROUP	**14. DO ANY OF THE CHILDREN IN YOUR CARE HAVE INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP) OR INDIVIDUALIZED EDUCATIONAL PLAN (IEP)?**	**15a. ARE YOU RELATED TO ANY CHILDREN IN YOUR CARE?** ❑ Yes ❑ No **15b. IF YES, HOW MANY ARE YOU RELATED TO?** _____ **16. DO YOU CARE FOR ANY CHILDREN WHO ARE DUAL LANGUAGE LEARNERS?** ❑ Yes ❑ No
____ Birth to 23 months ____ 2 years to 2 years, 11 months ____ 3 years to 5 years ____ School-age (K–6)	❑ Yes ❑ No	

SECTION 3: VERIFICATION OF EMPLOYMENT FOR CENTER STAFF and FAMILY CHILD CARE PROVIDERS

This information is to be completed by applicant's director or Family Child Care Network Administrator.

1a. I CERTIFY THAT THE APPLICANT:

❑ Works with at least three (3) children 0-13 years old receiving subsidized care in a CDE/EESD funded classroom.

1b. THE APPLICANT WORKS _____ HOURS A WEEK **1c. DATE OF HIRE:** _____**/**_____**/**_____
mm dd yyyy

2. _____**works at a CDE/EESD Funded Classroom**
Applicant's Name

or with a CDE/EESD funded Family Child Care Network. I understand that the incentive he/she receives is in addition to his/her annual salary, and I certify that the applicant's current salary will not be negatively affected. Furthermore, I declare under penalty of perjury that everything I have stated above is true.

_____	_____	_____/____/_____
Director Name / FCC Network Staff Name	*Director Signature / FCC Network Staff signature*	*mm dd yyyy*

SECTION 4: APPLICANT SIGNATURE

I understand that all stipend awards are not guaranteed and will be paid based on the availability of funds. I declare under penalty of perjury that everything I have stated in this application is true, correct, and complete. I understand if I provide false information to the AB212 CARES program and receive a stipend I will be required to return the full amount of the stipend. I understand that I am not eligible to receive a stipend with AB212 funds for any coursework that is already included in my participation in the CTKS program, through the San Diego County Office of Education. I understand that it is my responsibility to immediately update my personal information (name, address, phone number, and any changes in my employment). Failure to update my personal information may hinder my ability to receive important program information and to obtain an AB212 CARES stipend.

_____	_____/_____/_____
Signature of Applicant required	*mm dd yyyy*