



FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

APPLICATION FOR NEW APPLICANTS ONLY

Application Deadline: September 30, 2011

I WORK AT A:

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

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.**

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

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

Questions? Call the AB212 CARES toll-free line at 1.866.CARES SD (1.866.227.3773), send an email to caressd@ymcacr.org, or log on to www.ymcacr.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: _____

San Diego 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. DATE OF BIRTH _____/_____/_____ <i>mm dd yy</i>	
8. HOME ADDRESS		12. APT	13. CITY
14. ZIP			
15. HOME PHONE () _____ - _____	16. WORK PHONE () _____ - _____	17. CELL PHONE () _____ - _____	
18. E-MAIL ADDRESS <i>(required):</i>	19. INTERNET ACCESS? <input type="checkbox"/> Yes <input type="checkbox"/> No	20. FAX NUMBER <i>(if applicable)</i> () _____ - _____	

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.*

21a. WHAT IS YOUR PRIMARY LANGUAGE SPOKEN AT HOME? _____	22. WHICH RACE/ETHNICITY DO YOU MOST IDENTIFY YOURSELF WITH? <i>(Choose only one.)</i> <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other: _____
21b. WHAT LANGUAGE(S) DO YOU SPEAK WITH THE CHILDREN IN YOUR CARE? _____ _____	

MISCELLANEOUS INFORMATION

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

<input type="checkbox"/> Assistant Teacher	<input type="checkbox"/> Associate Teacher	<input type="checkbox"/> Teacher
<input type="checkbox"/> Master Teacher	<input type="checkbox"/> Site Supervisor	<input type="checkbox"/> Program Director

2. I AM CURRENTLY ENROLLED IN COLLEGE: Yes No

I AM ENROLLED OR WILL ENROLL AT _____ COLLEGE/UNIVERSITY.

I AM WORKING TOWARDS A _____ DEGREE IN _____*.

*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/CDD funded FCC Network
- I am an employee at a licensed family child care home that is part of a CDE/CDD funded FCC Network
- I work in a CDE/CDD funded child care center.

2. NAME OF CHILDCARE PROGRAM (as listed on license)**3. LICENSE NUMBER/EFFECTIVE DATE**

____/____/____
mm dd yyyy

LICENSE # _____

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. NUMBER OF CHILDREN IN EACH AGE GROUP

- _____ Birth to 23 months
- _____ 2 years to 2 years, 11 months
- _____ 3 years to 5 years
- _____ School-age (K-6)

12a. ARE YOU RELATED TO ANY CHILDREN IN YOUR CARE?

- Yes No

12b. IF YES, HOW MANY ARE YOU RELATED TO? _____**13. CURRENT JOB TITLE****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:** (Check all that apply)

- At least three (3) children 0-13 years old

1b. THE APPLICANT WORKS _____ HOURS A WEEK**2. _____ works at a CDE/CDD funded Child Care Center***Applicant's Name*

or with a CDE/CDD 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 it is my responsibility to immediately update my personal information (name, address, phone number, job site). 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