[ ]  HS [ ]  EHS [ ]  MSHS

|  |
| --- |
| List all children residing in the household ages 0-5 |
| Child’s Full Legal Name | Date of Birth | Age  | Gender | Has your child been diagnosed with asthma, seizures, allergies, or other medical concerns? |
|       |       |       |       | [ ]  No [ ]  Yes Describe:       |
|       |       |       |       | [ ]  No [ ]  Yes Describe:       |
|       |       |       |       | [ ]  No [ ]  Yes Describe:       |
| **YK, UG, KIT Sites Only**: Is there anyone in the home currently Pregnant? [ ]  No [ ]  Yes, If yes please complete: |
| Mother’s Full Legal Name | Date of Birth | Age | Due Date | Are there any Medical, Developmental, or Special Needs/Concerns |
|       |       |       |       | [ ]  No [ ]  Yes Describe: |

Parent/Guardian:       Cell/phone#       Language: [ ]  Span [ ]  Eng

Applicants Home Street Address:       City:       Zip:

\*\*\**Mailing address if different:*       City:       Zip:

Email Address:

If transportation would be available:

* 1. Which would be the pick-up address: ST:       City:       Zip:
	2. Which would be the drop-off address: ST:       City:       Zip:
1. If I am unable to reach you, who could I contact (emergency contact)?
	1. Name:       Relationship to you:       Phone:
2. How many people are living in your household related to you by blood, marriage, or adoption?
3. What is an estimate of your family’s total income last year? ­­­­­­­­­­­­­­­$
4. Select **ALL** that apply to your family:

[ ]  Possibly Homeless [ ]  Receiving TANF, SSI, or SNAP [ ]  Child in Foster Care

[ ]  Relocated in search of Agricultural work in the last 2 years [ ]  Has a family member that works for ESD105 or EPIC

[ ]  Legal circumstances involving the child: For example [ ]  Custody order [ ]  Parenting Plans [ ]  Restraining orders etc.

1. How did you hear about our program?
	1. Agency Referral through:       b. Recruitment Event:
2. Are you receiving other Early Learning Services? [ ]  ECEAP [ ]  Parents As Teachers [ ]  Other:
3. Does your child receive services at a School District or other agency for [ ]  Developmental Delay [ ]  Physical Therapy [ ]  Speech and Language [ ]  Cognitive [ ]  Behavior Health [ ]  Autism [ ]  ADHD [ ]  IFSP [ ]  IEP Where:
4. Is your child currently in the process of being evaluated to receive special services? If yes, explain:

|  |
| --- |
| **\*\*\* NOTE TO STAFF: The following script is to be read to the parent/guardian upon completion of intake \*\*\***Thank you for completing this information with us. Based on this information you MAY be eligible for one or more of our programs. Eligibility can only be determined after the eligibility process is completed. If you move/change phone numbers please call us to update your information. Someone will contact you to schedule an appointment. Staff Initials       |

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| --- | --- | --- | --- |
| Received by Enrollment Coordinator:Date:       Initials       | Placement by Transportation CENTER:       Initials       | Intake assigned to:Staff:       Date:       | Intake Transferred to:CENTER:       Date:       |

Printed Name of Staff Person Center of Origin Date

See Notes/Comments on the backside

|  |
| --- |
| Legal Last, First Middle Name:        |
| DateMM/DD/YY | Initials | Time  | Comments |
|        |        |       |        |
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