

CHILDREN'S PROGRAM PRE-APPLICATION

(please complete ONE form for each child)

Today's Date: _____

CHILD INFORMATION

Child's Last Name:	Child's First Name:	Child's Middle Name:
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Child's Date of Birth: _____	Child's Age (by September 1): _____
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PARENT/GUARDIAN INFORMATION

Last Name:	First Name:
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Street Address:	Home Phone:	Cell Phone:
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Apt #:	City:	State:	Zip Code:
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Email Address: _____

Are you employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you in school/training? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Are you currently homeless?: <input type="checkbox"/> Yes <input type="checkbox"/> No	What is your highest level of education?: _____
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ADDITIONAL PREQUALIFYING INFORMATION

Parental Status: Kinship Foster Care Teen Parent Single Parent Two Parent Household

What is your annual income (before taxes)?:	Are you currently receiving any public assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you authorized to receive child care subsidy for this child? <input type="checkbox"/> Yes <input type="checkbox"/> No	Family Size:
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Does your child have a diagnosed disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list the disability/IEP information?
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Do you suspect a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list why?
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PROGRAM OPTIONS

<input type="checkbox"/> Home-Based Early Head Start ~ age Birth-3yrs	<input type="checkbox"/> Early Head Start ~ age Birth-3yrs	<input type="checkbox"/> Full Day Kindergarten ~ age 4yrs
<input type="checkbox"/> Home-Based Head Start ~ age 3yrs-5yrs	<input type="checkbox"/> Full Day Head Start ~ age 3yrs	<input type="checkbox"/> Full Day Kindergarten ~ age 5yrs
<input type="checkbox"/> Early Head Start ~ Prenatal Services	<input type="checkbox"/> Part Day Head Start ~ age 3yrs	<input type="checkbox"/> Leaders of Tomorrow ~ age 5yrs-16yrs

How did you learn about our program? (please check **ONE** box):

<input type="checkbox"/> Radio Ads	<input type="checkbox"/> Flyer	<input type="checkbox"/> WIC Location - Name: _____	<input type="checkbox"/> Walk-In
<input type="checkbox"/> Community Event - Name: _____		<input type="checkbox"/> Neighborhood Canvassing	
<input type="checkbox"/> Parent Referral - Name: _____		<input type="checkbox"/> Other: _____	

Do you have other children/family members that are already enrolled in any of our NDF programs?
 Yes No If yes, please list name(s): _____

When is the best time to reach you?: _____

FOR OFFICE USE ONLY

Contact Date: _____	Follow-up Date: _____	Staff: _____
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