



Name: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB \_\_\_\_\_ Relation: \_\_\_\_\_

**Please note:** The following questions are asked to help us meet the requirements that our enrollment opportunities are made available to children with and without disabilities. Your response is voluntary, and the information about your child is confidential.

**Put an X in the column that best describes how your child is doing in each area of development.**

Area of Development	My child is doing OK	I'm a little worried
Motor Skills		
Understanding and Thinking Skills		
Speech/Language Skills		
Social/Emotional Skills		
Vision		
Hearing		

**Does your child have a diagnosed disability or health condition?** \_\_ yes      \_\_ no

**If yes, what is the diagnosis?** \_\_\_\_\_

**Name of doctor or agency who diagnosed your child?**  
\_\_\_\_\_

**Does your child receive any of the following services? (Check all that apply)**

- Speech Therapy    Provider: \_\_\_\_\_     Occupational Therapy    Provider: \_\_\_\_\_
- Physical Therapy    Provider: \_\_\_\_\_     Play Therapy    Provider: \_\_\_\_\_
- Special Instruction/Special Education Itinerant Teacher (SEIT)    Provider: \_\_\_\_\_

**If your child will be picked up or dropped off at another address, please fill out below:**

Name and Address: \_\_\_\_\_  
Phone: \_\_\_\_\_      Hours your child is at this address: \_\_\_\_\_

**Income Statement – Please fill out all that applies and send documentation of income.**

SSI                                      \$ \_\_\_\_\_      Monthly

Social Service TANF Grant      \$ \_\_\_\_\_      How Often - 1 X Month      2 X Month

Social Service Safety Net Grant    \$ \_\_\_\_\_      How Often - 1 X Month      2 X Month

Unemployment                      \$ \_\_\_\_\_      Weekly

Child Support                        \$ \_\_\_\_\_      How Often - Weekly      Monthly

1040 Adjusted Gross Income      \$ \_\_\_\_\_      Previous Year

Other: \_\_\_\_\_

**Current Employment: Below give gross amount (Before Deductions) of 4 most recent pay stubs and send verification.**

**1st Job**

Who is employed: \_\_\_\_\_      Place of Employment: \_\_\_\_\_

Type of Work: \_\_\_\_\_      How Often Paid? \_\_\_\_\_

Date Of Check \_\_\_\_\_      Gross Pay \$ \_\_\_\_\_      Date Of Check \_\_\_\_\_      Gross Pay \$ \_\_\_\_\_

Date Of Check \_\_\_\_\_      Gross Pay \$ \_\_\_\_\_      Date Of Check \_\_\_\_\_      Gross Pay \$ \_\_\_\_\_

**2nd Job**

Who is employed: \_\_\_\_\_      Place of Employment: \_\_\_\_\_

Type Of Work: \_\_\_\_\_      How Often Paid? \_\_\_\_\_

Date Of Check \_\_\_\_\_      Gross Pay \$ \_\_\_\_\_      Date Of Check \_\_\_\_\_      Gross Pay \$ \_\_\_\_\_

Date Of Check \_\_\_\_\_      Gross Pay \$ \_\_\_\_\_      Date Of Check \_\_\_\_\_      Gross Pay \$ \_\_\_\_\_

**Do you receive any of the following?**

- Food Stamps                       Other TANF Services                       Medicaid
- Child Care Subsidy               WIC     Child/Family Health Plus

**Assurance of Confidentiality:** The information on this form is being requested on a voluntary basis. It will help us to determine your Child's eligibility for Early Childhood Services and to prioritize your application. Some of the information provided may be used to help plan National program initiatives. All information supplied will be held in strict confidence.

**I certify the information provided in support of this application is accurate and truthful to the best of my knowledge. And if I misrepresent my circumstances, then Early Childhood Services has the right to not provide or discontinue services.**

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_