

DATE: ____/____/____

I receive CCIS or Child Care Subsidy

Eligibility Specialist Name: _____

Phone Number: _____

Hosanna House, Inc. Child Care Center Intake Form

For Office Use Only

Date Received: ____/____/____

Enrollment Date: ____/____/____

Withdrawal Date: ____/____/____

Please Complete All Sections

A. Please type or print clearly. Complete all sections of this form and date in last section. If you need help completing this form, another person may help you, or you may call your lead Agency for assistance.

Last name of Parent/Guardian	First Name	MI	Home Phone: () Work Phone: ()
Home Address	Apt.#	City	State/Zip Code

B. Enter the information below for yourself and all the persons who live with you:

Last Name	First Name	MI	Date of Birth	M/F	Relationship to you	Social Security #	Are you requesting service for this child?

C. For any child in Section B for whom CDC care is being requested, please fill in the following information:

Child's first name	Name he/she prefers to be called	Current Child Care

D. Child's Special Needs Determinations (if applicable). Explain further on lines provided.

_____Physical _____Emotional _____Psychological _____Social

E. Child' Medical Information:

Health Care Coverage Provider _____ Policy Agreement # _____

Child's Physician _____ Phone Number _____

Allergies _____ Medication _____

Other Dietary Requirements or Limitations (e.g. vegetarian, religious restrictions – please be specific as possible)

Emergency medical care is the financial responsibility of the parent or guardian signing this agreement

<p>F. What type of care do you need?</p> <p>_____ Infant Care (6wks-12mos) _____ Preschool (36mos+)</p> <p>_____ Young Toddler (12mos-24mos) _____ After School (K-3rd)</p> <p>_____ Older Toddler (24mos-36 mos)</p>	<p>G. During what days and hours do you need care on a regular basis?</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 5%;"></td> <td style="width: 12.5%;">Sun</td> <td style="width: 12.5%;">Mon</td> <td style="width: 12.5%;">Tues</td> <td style="width: 12.5%;">Wed</td> <td style="width: 12.5%;">Thur</td> <td style="width: 12.5%;">Fri</td> <td style="width: 12.5%;">Sat</td> </tr> <tr> <td style="text-align: left;">From:</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: left;">To:</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>		Sun	Mon	Tues	Wed	Thur	Fri	Sat	From:								To:							
	Sun	Mon	Tues	Wed	Thur	Fri	Sat																		
From:																									
To:																									

H. Please answer all that apply:		
	Currently Receiving	Last Received (Date)
Cash Assistance		
Medical Assistance		
Food Stamps		
<p>DPW Record Number: Enter the nine digit number assigned by the County Assistance Office</p> <p>Food Stamp or TANF Cash Assistance Number:</p> <p>_____</p>		
<p>Foster Child: Yes _____ No _____</p>		
<p>Is there a court order in place? If yes, please provided appropriate documentation.</p>		

I. Yes No Are you currently employed? If yes, complete this section.

Yes No Is your spouse/live-in companion employed? If yes, complete this section.

Name of Person Employed	Name of Employer	Employer Phone Number	Usual # of hours Worked/Week	Usual # of days Worked/Week

J. Yes No Are you currently enrolled in a training program? If yes, please name program and location:

PROGRAM _____ TRAINING SITE _____

Yes No Is your spouse or live-in companion in a training program? If yes, please name program name and location.

PROGRAM _____ TRAINING SITE _____

K. Household Information (THIS SECTION MUST BE COMPLETED)

Indicate if you or anyone who lives with you receives money from:	Yes	No	Person's Name	Gross Monthly Amount	How Often
Wages, Salaries, Commissions, Training Allowances, Tips					
Self Employment					
Child Support or Alimony					
Dividends or Interest Stocks, Bonds, Saving, etc.					
Public Assistance of State Blind Pension					
Social Security Benefits					
SSI or Black Lung Benefits					
UMWA (United Mine Workers) or other Union Benefits or other Sources please specify					

L. Affidavit:

I authorize the Hosanna House, Inc. Child Development Center to provide the above health care coverage information to any physician or hospital to pay for emergency care. I also give permission for the Hosanna House, Inc. Child Development Center to call or to have a hospital call the above named physician in the event of an emergency. If my insurance does not fully cover these costs, I agree to be liable to the hospital for payment.

I affirm that I have read – or had read to me – this application in full and all information I have given is true, correct, and complete to the best of my ability, knowledge and belief.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

FOR OFFICE USE ONLY

LEAD AGENCY SIGNATURE _____ ***DATE*** _____