HAMILTON MADISON HOUSE

Early Childhood Services Application

Child (Applicant)

First Name	Middle Name	Last Name	Gender ☐ Male ☐ Female	Birth Date

Living Address	City/ Zip

Is child in Foster Care? ☐ Yes ☐ No

Ethnicity
☐ Hispanic/Latino
☐ Non-Hispanic /Non-Latino

Race
☐ Asian
☐ White (European, Middle Eastern, North African)
☐ Black/African American
☐ Pacific Islander/Hawaiian
☐ American Indian/Alaskan
☐ More than one race (Bi-racial/Multi-racial)
☐ Other

Primary language spoken at home ☐ English ☐ Spanish ☐ Chinese ☐ Other

What language does your child use the most? ☐ English ☐ Spanish ☐ Chinese ☐ Other

Child Information – Health

Does this child have medical insurance? ☐Yes ☐No
If yes, what type? ☐Medicaid ☐Private Insurance ☐Child Health Plus ☐Other

Does this child have a regular doctor or medical clinic? ☐Yes ☐No
Name of clinic/provider: Name of medical professional:

Did this child have a well-child exam within the last 12 months?
☐ Yes – Date of last exam (month/day/year):
☐ No ☐Date Unknown

What is your child's immunization status? ☐Fully immunized ☐Exempt ☐Not fully immunized or exempt ☐Not sure

Does this child have dental insurance? ☐Yes ☐No
If yes, what type? ☐Medicaid ☐ Private Insurance ☐Child Health Plus ☐ Other

Does this child have a regular dentist or dental clinic? ☐Yes ☐No
Name of clinic/provider: Name of dental professional:

Has this child been diagnosed by a Health Care Provider with a chronic health condition (may include asthma, cancer, diabetes, seizures, ADHD, autism, spine bifida, sickle cell disease, or life-threatening allergies)?
☐ Yes – Please describe: The health condition is considered: ☐Severe ☐Moderate ☐Mild
☐ No

Child Information - Development

Do you have concerns about this child's health? ☐Yes – check all that apply below ☐No

☐ Low birth weight (less than 5.5 lbs/5 lbs 8 oz.)
☐ Hearing
☐ Vision
☐ Preterm birth less than 37 weeks
☐ Fine motor/gross motor
☐ Food intolerance / special diet
Please describe:
☐ Drug/alcohol affected
☐ Heart Condition
☐ Other

Does this child have a **current and active** Individual Education Plan (IEP) or Individual Family Service Plan (IFSP)?
☐ Yes – Please provide a copy with your application.
☐ No – Check if any of these apply:
☐ My child has a diagnosed developmental delay or disability, has no IEP, **or** is being referred for evaluation.
☐ My child has a suspected developmental delay or disability.

Family Information

Primary language spoken at home ☐ English ☐ Spanish ☐ Chinese ☐ Other

Parents/Guardians in the Home
☐ One Parent ☐ Two Parents

What language would you like to receive written information?
☐ English ☐ Spanish ☐ Chinese ☐ Other

Primary Parent/Guardian's Name | **Birth Date** | **Gender** ☐F ☐ M

Address

Ethnicity
☐ Hispanic/Latino
☐ Non-Hispanic /Non-Latino

Race
☐ Asian ☐ Pacific Islander/Hawaiian
☐ White ☐ American Indian/Alaskan
☐ Black/African American ☐ Bi-racial/Multi-racial
☐ Other

Lives with the Child ☐ Yes ☐ No

Marital Status
☐ Married ☐ Single
☐ Divorced ☐ Separated
☐ Widowed

Cell Phone Number
Opt in to received Text Message
☐ Yes ☐ No
( )

Relationship to Child
☐ Biological Parents ☐ Adopted / Stepparent
☐ Foster Parents ☐ Aunt/ Uncle
☐ Grandparent ☐ Other

Primary Parent/Guardian's Email Address

Alternate Phone Number
☐ Cell ☐ Home ☐ Work ☐ Other
( )

Education
☐ Less than High School ☐ Some College or AA/AS
☐ High School Grad or GED ☐ Bachelor's / Advanced Degree

Secondary Parent/Guardian's Name | **Birth Date** | **Gender** ☐F ☐ M

Address

Ethnicity
☐ Hispanic/Latino
☐ Non-Hispanic /Non-Latino

Race
☐ Asian ☐ Pacific Islander/Hawaiian
☐ White ☐ American Indian/Alaskan
☐ Black/African American ☐ Bi-racial/Multi-racial
☐ Other

Lives with the Child ☐ Yes ☐ No

Marital Status
☐ Married ☐ Single
☐ Divorced ☐ Separated
☐ Widowed

Cell Phone Number
Opt in to received Text Message
☐ Yes ☐ No
( )

Relationship to Child
☐ Biological Parents ☐ Adopted / Stepparent
☐ Foster Parents ☐ Aunt/ Uncle
☐ Grandparent ☐ Other

Secondary Parent/Guardian's Email Address

Alternate Phone Number
☐ Cell ☐ Home ☐ Work ☐ Other
( )

Education
☐ Less than High School ☐ Some College or AA/AS
☐ High School Grad or GED ☐ Bachelor's / Advanced Degree

Eligibility

Primary Parent/Guardian

Primary Parent/Guardian's Name | Has Income ☐ Y ☐ N

Employment Status

☐ Employed ☐ Seasonally Employed ☐ Retired
☐ Unemployed ☐ Seeking Employment ☐ Student
☐ Disabled ☐ Incapacitated From_____ to _____

Employment Information

Employer Name | Employer Phone ( )

Employer Name | Employer Phone ( )

Pay Periods ☐ Weekly ☐ Every 2 Weeks ☐ Twice Per Month ☐ Monthly

Gross Income $_____ Per_____

School/Training Information

Are you in School or Training? ☐ Yes ☐ No | Hours:

School Name | School Phone ( )

Secondary Parent/Guardian

Secondary Parent/Guardian's Name | Has Income ☐ Y ☐ N

Employment Status

☐ Employed ☐ Seasonally Employed ☐ Retired
☐ Unemployed ☐ Seeking Employment ☐ Student
☐ Disabled ☐ Incapacitated From_____ to _____

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Gross Income $_____ Per_____

School/Training Information

Are you in School or Training? ☐ Yes ☐ No | Hours:

School Name | School Phone ( )

Family Concerns

Please check areas of concern that you have for yourself/family in your household:

☐ Child's parent/guardian has a disability or is chronically ill and is:
- ☐ Unable to engage in work/school/family life
- ☐ Somewhat able to engage in work/school/ family life
- ☐ Mostly able to engage in work/school/family life

☐ Child's parent/guardian has learning difficulties, no disability

☐ Household mental illness, including maternal depression (child is diagnosed, or adult is experiencing)

☐ Household domestic violence (past or current)

☐ Household drug/alcohol issues or substance abuse (past or current)

☐ Family is socially isolated, with complete or near-complete lack of contact with others

☐ Getting or keeping a job

☐ Legal concerns

☐ Child's parent/guardian is a migrant worker

☐ Recent immigrant/refugee (past 5 years)

☐ Child's parent/guardian is incarcerated

☐ Loss of a parent (death, abandonment, or deportation)

☐ Child's parents/guardians divorced or separated during child's life

☐ Previously homeless (in the last 12 months)

☐ Concerns with housing

Family Living Situation

Does this household receive subsidized housing such as a housing voucher or cash assistance for housing? ☐Yes ☐No

What is your family's current housing situation? **The McKinney-Vento Act provides services and supports for children and youth experiencing homelessness. Your answers may help us determine the services your child may be eligible to receive.**

☐ Rent ☐ In a motel ☐ A car, park, campsite, or similar location ☐ Moving from place to place/couch surfing

☐ Own ☐ In a shelter ☐ Transitional Housing ☐ In a residence with inadequate facilities (no water, heat, electricity)

☐ In someone else's house or apartment with another family:
- ☐ By choice (e.g. to save money, to be close to family, etc.)
- ☐ Due to loss of housing, economic hardship, or similar reason

☐ Other – Please describe:

Family Income and Family Size

Check all that apply if you, this child, or another person living in your home related to you by blood, marriage, or adoption receive these types of Public Assistance:

☐ SSI for disability received by: ☐Child ☐Parent/Guardian ☐Other – Relationship to child:

☐ Temporary Assistance for Needy Families (TANF) cash.

☐ SNAP

Please list additional people living in this child's primary household below, not including yourself or this child.

Name (First and Last)	Birthdate (month/day/year)	Relationship to child	Do you financially support this person?	Is this person related to you by blood, marriage, or adoption?
			☐ Yes ☐No	☐ Yes ☐No
			☐ Yes ☐No	☐ Yes ☐No
			☐ Yes ☐No	☐ Yes ☐No
			☐ Yes ☐No	☐ Yes ☐No
			☐ Yes ☐No	☐ Yes ☐No
			☐ Yes ☐No	☐ Yes ☐No
			☐ Yes ☐No	☐ Yes ☐No

What is the **total number** of family members living in your home, including yourself and this child?

What is your **total estimated** household income for the last calendar year or the last 12 months?

I acknowledge the information on this form is true. I have reported all my income and family size, as required by the Programs. If I knowingly provide false information, I understand my family may be unable to continue program services. Funded agencies will review all provided information.

Parent/Guardian Signature_____ **Date** _____

Staff Only			
Child's Age:	**Total Verified Family Size:**	**Total Verified Income:**	**Total Points:**
Site Name/ID:		**Date received:** (This date will determine eligibility timeframe)	
Date staff reviewed application with family:		**Date submitted:**	

For Homeless Families – Check the services that are needed or desired by the family and provide resources as soon as possible:

- ☐ Child care resources
- ☐ Clothing resources
- ☐ School supplies
- ☐ Medical/dental referral
- ☐ Housing/shelter referral
- ☐ Immunization/medical records
- ☐ Vision referral
- ☐ Hygiene products/toiletries
- ☐ Food resources
- ☐ Birth certificate
- ☐ Medicaid/ Food stamps/TANF
- ☐ College/vocational/technical resources
- ☐ Other

Staff Name & Signature: **Date:**

If parent/guardian can't sign during Covid 19 virtual interview and enrollment, complete below.
Parent signature must be obtained as soon as possible, or no later than the onsite enrollment visit.

Reviewed and received verbal verification on (date): **Staff Name:**