



Protecting children.  
Strengthening families.

# Child Development Services Preliminary Application

Site:  Kids Hope  Bridgeport  Bridgeport II  Elgin  
 Busy Bee  Pickus  Home-based program

*All preliminary applications are effective for one calendar year ONLY.*

Date: \_\_\_\_\_

## Child Information

Child's name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Child's age: \_\_\_\_\_ Child's gender:  Male  Female

What kind of child care program do you need?  Preschool  School-age  Home visiting  Referral

Race/ethnicity:  Hispanic  African American  Asian  Caucasian  Other: \_\_\_\_\_

Primary language spoken in the home: \_\_\_\_\_ Number of family members (living in home): \_\_\_\_\_

Annual gross family income: \_\_\_\_\_ Weekly/hourly income: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

## Family Information

Primary parent/guardian name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone number(s): Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email Address: \_\_\_\_\_

Marital status: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Race/ethnicity:  Hispanic  African American  Asian  Caucasian Other: \_\_\_\_\_

Check one:  Employed  Training  School Working/school hours: \_\_\_\_\_

May we call your place of employment once we have an opening?  Yes  No

Secondary parent/guardian name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone number(s): Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Marital status: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Race/ethnicity:  Hispanic  African American  Asian  Caucasian Other: \_\_\_\_\_

Check one:  Employed  Training  School Working/school hours: \_\_\_\_\_

May we call your place of employment once we have an opening?  Yes  No

How did you hear about this program?

Advertisement Describe: \_\_\_\_\_  Web site  Yellow Pages  Sign  Friend/family  
 Resource referral  Parent referral  Flyer  Other: \_\_\_\_\_

Do you have another child(ren) enrolled in our Child Development Program?  Yes  No

If so, what is the child(ren)'s name(s)? \_\_\_\_\_  
\_\_\_\_\_

Does your child have any special needs?  Yes  No

Check all that apply:  Physical  Hearing impairment  Delayed development  
 Other (please list): \_\_\_\_\_

### For Head Start programs only

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1. Has a screening completed by an early childhood or medical specialist resulted in a concern regarding your child's development?  Yes  No

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

2. Does your child have a chronic health need?  Yes  No

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

3. Do you or another parent/guardian have any special needs?  Yes  No

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

4. Have you recently immigrated to the United States?  Yes  No If so, when? \_\_\_\_\_

5. Are you living with a relative or in a shelter? \_\_\_\_\_

### For office use only

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Date of contact

Outcome

Head Start Point System