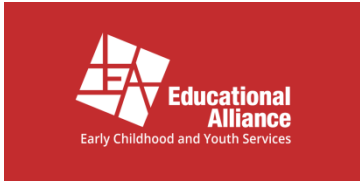


Date: _____ (Office Use Only) PID ID: _____		Applying for: <input type="checkbox"/> Early Head Start <input type="checkbox"/> Head Start <input type="checkbox"/> Early Learn <input type="checkbox"/> UPK <input type="checkbox"/> First Available Seat Locations: <input type="checkbox"/> Manny Cantor Center <input type="checkbox"/> Lillian Wald <input type="checkbox"/> PS 64 <input type="checkbox"/> PS 142 <input type="checkbox"/> Home-based <input type="checkbox"/> PS 134 <input type="checkbox"/> PS 188
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Family Development Options

(At Ed Alliance, we want every parent to participate in one or more of the following programs. Family all-inclusive learning experiences are grouped into pathways of interest. Please rank in order of interest 1- 3, with 1 as most interested)

- _____ **Family Well-Being & Parenting (Parenting Education, Parent Support Groups, Father/Male Involvement)**
- _____ **Adult Education and Career (ESOL, HSE/GED, Job Search, Career Coaching, Financial Coaching)**
- _____ **Community Leadership (Classroom Representative, Parent Leaders, School Involvement)**

<u>Child's Last Name</u>	<u>Child's First Name</u>	<u>Child's DOB</u>	<u>Child's Gender</u>
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1. Parent/Guardian First Name: _____ Last Name: _____ Address: _____ Apt # _____ Zip Code _____ Relationship to Child: _____	2. Parent/Guardian First Name: _____ Last Name: _____ Address: _____ Apt # _____ Zip Code _____ Relationship to Child: _____	Language(s) Spoken 1) _____ 2) _____ How did you hear about our program? <input type="checkbox"/> Family <input type="checkbox"/> Friends <input type="checkbox"/> Website <input type="checkbox"/> Email <input type="checkbox"/> Flyer <input type="checkbox"/> Other
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Contact Information Home: _____ Cell: _____ Work: _____ Email: _____	Contact Information Home: _____ Cell: _____ Work: _____ Email: _____	Is anyone in your household pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Due date: _____ Name(if not yourself): _____ Relationship: _____
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<p style="text-align: center;"><u>Race (Check all that apply)</u></p> <p style="text-align: center;"><i>C= Child, P/G1= Parent/Guardian 1, P/G2= Parent/Guardian 2</i></p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Asian (Far East, Southeast Asia, Indian Subcontinent)</td> <td style="text-align: center;">C</td> <td style="text-align: center;">P/G1</td> <td style="text-align: center;">P/G2</td> </tr> <tr> <td><input type="checkbox"/> American Indian / Alaskan Native</td> <td style="text-align: center;">C</td> <td style="text-align: center;">P/G1</td> <td style="text-align: center;">P/G2</td> </tr> <tr> <td><input type="checkbox"/> Black (African American/of a Black racial group)</td> <td style="text-align: center;">C</td> <td style="text-align: center;">P/G1</td> <td style="text-align: center;">P/G2</td> </tr> <tr> <td><input type="checkbox"/> Native Hawaii / Pacific Islander</td> <td style="text-align: center;">C</td> <td style="text-align: center;">P/G1</td> <td style="text-align: center;">P/G2</td> </tr> <tr> <td><input type="checkbox"/> White (Europe, Middle East, North Africa)</td> <td style="text-align: center;">C</td> <td style="text-align: center;">P/G1</td> <td style="text-align: center;">P/G2</td> </tr> <tr> <td><input type="checkbox"/> Other (Race not listed)</td> <td style="text-align: center;">C</td> <td style="text-align: center;">P/G1</td> <td style="text-align: center;">P/G2</td> </tr> <tr> <td><input type="checkbox"/> Unspecified/Unknown</td> <td style="text-align: center;">C</td> <td style="text-align: center;">P/G1</td> <td style="text-align: center;">P/G2</td> </tr> </table>	<input type="checkbox"/> Asian (Far East, Southeast Asia, Indian Subcontinent)	C	P/G1	P/G2	<input type="checkbox"/> American Indian / Alaskan Native	C	P/G1	P/G2	<input type="checkbox"/> Black (African American/of a Black racial group)	C	P/G1	P/G2	<input type="checkbox"/> Native Hawaii / Pacific Islander	C	P/G1	P/G2	<input type="checkbox"/> White (Europe, Middle East, North Africa)	C	P/G1	P/G2	<input type="checkbox"/> Other (Race not listed)	C	P/G1	P/G2	<input type="checkbox"/> Unspecified/Unknown	C	P/G1	P/G2	<p style="text-align: center;"><u>Ethnicity</u></p> <input type="checkbox"/> Hispanic / Latino Origin C, P/G1, P/G2 <input type="checkbox"/> Non-Hispanic / Non-Latino Origin C, P/G1, P/G2
<input type="checkbox"/> Asian (Far East, Southeast Asia, Indian Subcontinent)	C	P/G1	P/G2																										
<input type="checkbox"/> American Indian / Alaskan Native	C	P/G1	P/G2																										
<input type="checkbox"/> Black (African American/of a Black racial group)	C	P/G1	P/G2																										
<input type="checkbox"/> Native Hawaii / Pacific Islander	C	P/G1	P/G2																										
<input type="checkbox"/> White (Europe, Middle East, North Africa)	C	P/G1	P/G2																										
<input type="checkbox"/> Other (Race not listed)	C	P/G1	P/G2																										
<input type="checkbox"/> Unspecified/Unknown	C	P/G1	P/G2																										

HOUSEHOLD MEMBERS (Other than Applicant or Parents/Legal Guardians)						
	Name	DOB	Gender	Languages Spoken	Relationship to Child	Financially Supported (v)
1						
2						
3						
4						

Has your child participated in any other early child care setting? <input type="checkbox"/> Yes <input type="checkbox"/> No Type of Program: <input type="checkbox"/> Family Day Care <input type="checkbox"/> Preschool <input type="checkbox"/> Play Groups <input type="checkbox"/> Private <input type="checkbox"/> Other
Does your child have a sibling currently enrolled in any of our Educational Alliance Programs? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of sibling and name of program: _____
Does your child have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what kind? _____
Does your family have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what kind? _____

Child's Name:	Date of Birth:	PID:
Special Situation or Needs That Our Program Should Be Aware Of		
1. Does your child have any diagnosed medical conditions / allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what kind?		
2. Does your child receive treatment for the medical conditions / allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what kind?		
3. Does your child have any special physical needs? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please explain:		
4. Do you have any concerns about your child's development or behavior? <input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently If so, please explain:		
5. Has your child ever been screened for any child development concerns (including speech and language)? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please explain:		
If you answered Yes to any questions above, please complete questions 6 - 9. <b style="background-color: yellow;">We need detailed information in order to best serve your child.		
6. Is your child currently in the special needs evaluation process? <input type="checkbox"/> Yes <input type="checkbox"/> No		
7. Has your child been diagnosed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
8. Have you been given an IFSP or IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you currently have an IFSP or IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please provide us with a copy)		
9. What services is your child receiving? (please check all that apply) <input type="checkbox"/> ST <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> SEIT Has your child been recommended for any other services? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:		
Selection Criteria: Please indicate whether any of the following categories are applicable to your family. Check all that apply. This information is CONFIDENTIAL.		
<input type="checkbox"/> Active ACS Case <input type="checkbox"/> Adolescent Parent (21 or younger) <input type="checkbox"/> Diagnosed Disability Parent <input type="checkbox"/> English is a second language <input type="checkbox"/> Foster Child <input type="checkbox"/> Housing Needs (Homeless/Shelter) <input type="checkbox"/> Housing Needs (Unsafe/Overcrowded) (# of people _____ / # of bedrooms _____) <input type="checkbox"/> Parents are immigrants within the last 3 years <input type="checkbox"/> Parent / Child in Counseling <input type="checkbox"/> One Parent Incarcerated/recently discharged w/i the last 3 yrs <input type="checkbox"/> Both Parents Incarcerated/recently discharged w/i the last 3 yrs	<input type="checkbox"/> Parent in School / Training/Employed <input type="checkbox"/> Receiving Preventive Services (Court/ACS Mandated Services, Family Preservation Services, ACS Preventive Services) <input type="checkbox"/> Parent enrolled in Job Center <input type="checkbox"/> Sibling enrolled in EC&E Program in upcoming school year Program/Site: _____ <input type="checkbox"/> One- Parent Household <input type="checkbox"/> One-Parent Household Unemployed Two-Parent Household: <input type="checkbox"/> One Parent Unemployed <input type="checkbox"/> Both Parent Unemployed Referred from Outside Agency: _____ <input type="checkbox"/> Other: _____	
Is there anything else you would like us to know about your child / family at this time? _____ _____		
<u>DISCLAIMER</u> By submitting this application I confirm that all information provided is true and accurate at this time. I understand that any misstatement, omission, or statement of facts that are subsequently found to be false may prejudice or forfeit an offer of admission to the program.		
Parent/Guardian Signature: _____ Date: _____		
Staff Assisting w/Application: _____ Date: _____		
Staff Received Application: _____ Date: _____		