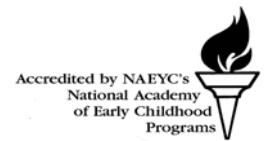


# Child Development Center

Provider of comprehensive Early Head Start

2441 Kenwood Circle, P.O. Box 698, Mansfield, Ohio 44901 ♦ Phone: 419-755-5600 ♦ Fax: 419-755-5605



## APPLICATION

Child Information			
Last Name:		First:	
		M.I.	
Child's Date of Birth:		Child's Race (check all that apply): <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native American or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unspecified <input type="checkbox"/> Other:	
Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female			
Child's Social Security Number:			
Child's Primary Language Spoken:			
Is child a transfer from an Early Head Start program? <input type="checkbox"/> No <input type="checkbox"/> Yes    Name of program:			
Has the child been identified with a disability? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Suspected			
Does the child have any physical or health conditions? <input type="checkbox"/> No <input type="checkbox"/> Yes    Describe:		Child's Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino	
Family Information			
Primary Parent/Guardian Last Name:		First:	
Relationship to Child:		Parent's Social Security Number:	
Parent's Date of Birth:		Parent's Primary Language Spoken:	
Mailing Address:		City:	Zip Code:    County:
Home Phone:		Cell:	Other:
Email:		Student Status: <input type="checkbox"/> NC State <input type="checkbox"/> OSU-M <input type="checkbox"/> N/A	
Employer:		(If a student, please submit copy of class schedule)	
—If one-parent household, skip down to Additional Family Member if applicable —			
Other Parent/Guardian Last Name:		First:	
Parent's Date of Birth:		Social Security Number:	
Phone:		Parent's Primary Language Spoken:	
Email:		Student Status: <input type="checkbox"/> NC State <input type="checkbox"/> OSU-M <input type="checkbox"/> N/A	
Employer:		(If a student, please submit copy of class schedule)	
Additional Family Member Last Name:		First:	
Relationship to Child:		Date of Birth:	
Additional Family Member Last Name:		First:	
Relationship to Child:		Date of Birth:	
Additional Family Member Last Name:		First:	
Relationship to Child:		Date of Birth:	
Additional Family Member Last Name:		First:	
Relationship to Child:		Date of Birth:	
Does any other immediate family member have any serious medical, physical, or mental health conditions? <input type="checkbox"/> No <input type="checkbox"/> Yes    Describe:			
Please indicate any issues which have occurred within the immediate family in the past year:			
<input type="checkbox"/> Child Abuse or Neglect	<input type="checkbox"/> Death	<input type="checkbox"/> Divorce	
<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Foster Care Placement	<input type="checkbox"/> Frequent Moves/Homelessness	
<input type="checkbox"/> Incarceration	<input type="checkbox"/> Military Deployment	<input type="checkbox"/> Other:	

The Child Development Center receives federal funding for Early Head Start and the Child and Adult Care Food Program. Completion of the following section will help staff to determine initial eligibility.

### Family Income Information

For program purposes, family is defined as all persons living in the same household who are: (1) supported by the income of the parent(s) or guardian(s) of the child enrolling or participating in the program, **and** (2) related to the parent(s) or guardian(s) by blood, marriage, or adoption. Also, income means total cash receipts **before taxes** from all sources.

Family Member (including self)	Amount	Gross Income Type	Income Source
		<input type="checkbox"/> Monthly <input type="checkbox"/> Annual	
		<input type="checkbox"/> Monthly <input type="checkbox"/> Annual	
		<input type="checkbox"/> Monthly <input type="checkbox"/> Annual	
		<input type="checkbox"/> Monthly <input type="checkbox"/> Annual	
		<input type="checkbox"/> Monthly <input type="checkbox"/> Annual	
<b>Total Gross Annual Income</b>			<b>\$</b>

**Please indicate the types of service or assistance currently receiving: (Mark all that apply)**

<input type="checkbox"/> Child Care Subsidy	<input type="checkbox"/> Food Stamps	<input type="checkbox"/> Financial Aid
<input type="checkbox"/> Medicaid/Medicare	<input type="checkbox"/> SSI	<input type="checkbox"/> TANF/OWF
<input type="checkbox"/> WIC	<input type="checkbox"/> No service/assistance received	<input type="checkbox"/> Other:

### Childcare Information

The Child Development Center provides early care and education in a full-year program operating Monday through Friday from 7:00 a.m. to 6:00 p.m. We offer full week and partial week scheduling with a **minimum enrollment of 10 hours** and 2 days per week.

Early Head Start provides additional supports for eligible families of infants and toddlers through a center-based program. The CDC also offers a home-based program which includes weekly home visits from CDC staff and monthly group socializations. This program option provides comprehensive services to families who may not currently need childcare.

Type of care needed:	<input type="checkbox"/> Full Week (25-55 hrs)	<input type="checkbox"/> Partial Week (10-24.9)	<input type="checkbox"/> AM	<input type="checkbox"/> PM		
Days of week care needed:	<input type="checkbox"/> M-F	<input type="checkbox"/> M-TH	<input type="checkbox"/> MWF	<input type="checkbox"/> TTHF	<input type="checkbox"/> MW	<input type="checkbox"/> TTH
Reason for care:	<input type="checkbox"/> Work	<input type="checkbox"/> School	I work and/or take classes in the summer (June-August)?:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
I am interested in enrollment in the CDC's Early Head Start home-based program:					<input type="checkbox"/> Yes	<input type="checkbox"/> No

I agree that the information provided is true and accurate. The CDC will not share this information with others and will use it to determine initial eligibility for enrollment into the Center and Early Head Start.

\_\_\_\_\_  
Primary Parent/Guardian Signature

\_\_\_\_\_  
Date

#### For Office Use Only

Date Received:	Time Received:	Initials:
1 <sup>st</sup> Refusal Date:	Date Application Removed:	Initials: