



Child Care Program Screening Application Form 2075

All forms must be completed in ink; white-out NOT accepted.

Name	SSN	Phone No.
Physical Address, City, State & Zip		Mailing Address, City, State & Zip

Marital Status: Single Divorced Separated Widowed Married
 Priority of Service: Transitional CPS Qualified Veteran Foster Care Youth Teen Parent Child w/ Disability

Special consideration may be given to parents who have a child/children with disabilities. If you would like to apply for these services, please indicate if your child/children have a physical (motion, vision, hearing, asthma, etc.) or mental (learning or developmental) impairment that substantially limits one or more of his/her major life activities? Yes No

WHO LIVES IN YOUR HOUSEHOLD? *(Include yourself in the household.)*

No.	GENDER <i>(CIRCLE)</i>	RACE <i>(Optional)</i>	DISABILITY?	NAME <i>(FIRST, M.I., LAST)</i>	DATE OF BIRTH	SOCIAL SECURITY No.	RELATION TO YOU <i>(son, daughter, husband, boyfriend, etc.)</i>	CHILD CARE NEEDED?
1	M OR F			SELF				Y OR N
2	M OR F							Y OR N
3	M OR F							Y OR N
4	M OR F							Y OR N
5	M OR F							Y OR N
6	M OR F							Y OR N

WHO RECEIVES INCOME IN YOUR HOUSEHOLD? *(Include everyone in the household who receives income, including child support payments.)*

NAME <i>(FIRST, M.I., LAST)</i>	GROSS INCOME PER MONTH?	SOURCE OF INCOME <i>(Child Support, SSI, Employment, Self-Employment)</i>	IF EMPLOYED LIST NAME OF EMPLOYER	WORK #	START DATE	HRS PER WEEK?	HOURLY RATE?	HOW OFTEN ARE YOU PAID?

ARE YOU CURRENTLY ATTENDING SCHOOL? Yes No

Hours enrolled? _____ School Name: _____ Declared Major: _____

DO YOU ALREADY HAVE A CHILD CARE PROVIDER SELECTED? Yes No

IF YES, LIST NAME: _____

HOW DID YOU HEAR ABOUT WORKFORCE SOLUTIONS CHILDCARE SERVICES? Radio Newspaper Daycare Flyer/Brochure Other

Applicant Signature _____ Date ____ - ____ - ____