Miami Valley MVCDC Child Development Centers, Inc.

Parents: This is the first phase of MVCDC's application process. Please complete & print this form. Call 937.226.5664 to schedule an enrollment interview. Bring form with you.

# Enrollment Application

| | | |
|---|---|---|
| ☐ **Head Start** □ *AM* □ *PM* □ *FD* □ *HB* | ☐ **1st** Yr ☐ **2nd** Yr ☐ **3rd** Yr | ☐ **Partnership** |
| ☐ **Family Child Care** | ☐ **EHS** ☐ **State** | ☐ **Public Preschool** |

County _____ Center/Classroom _____ Child SS #:____/____/____

Child's Name _____ ☐M ☐F Child DOB _____ Ref Document _____

Parent/Guardian Name _____ Phone _____

Address _____City_____ Zip Code _____School Dis _____

**RACE:** W B A N P M O U **Ethnicity:** Hispanic Non Hispanic **Language:** E S M C I A N P W L O

*(Primary language of family)*

| Names of Family Member | Relation | Birth Date | Social Security # | Education | Place of Employment/School |
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| **Codes for Relationships** | HOH = Head Of Household | M = Mom | F = Father | S = Step Parent | FP = Foster Parent/Guardian |
| | GP =Grandparent | BR= Brother | SIS = Sister | | O = Other |

| | | | | | |
|---|---|---|---|---|---|
| **Family Type:** | ☐ Two Parent ☐ Single Parent | | | | |
| **HOH Employed:** | ☐ Full Time | ☐Part Time | ☐ Seasonal | ☐ Unemployed | ☐ School/Training |
| **Adult #2 Employed** | ☐ Full Time | ☐ Part Time | ☐ Seasonal | ☐ Unemployed | ☐ School/Training |
| **Housing Type** | | ☐ Apt | ☐ Single Family | ☐ Public Housing | ☐ Homeless |
| **Child Day Care Needs:** | ☐ Full Day | ☐Part Day | ☐ 2nd or 3rd Shift | ☐Child Care not needed | |
| **Child receives care at:** | Name of Provider | | ☐ Child Care Center | ☐ Home Daycare | ☐ Other adult/ relative |

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|---|---|---|---|---|---|
| **Currently receives:** ☐ ODJFS childcare subsidy | | | | | |
| **Family issues** | ☐ Abuse/Domestic Issues | ☐ Legal Issues | ☐Substance/Alcohol Abuse | ☐Change in Parental Figure | ☐Health Issues |
| **Services received from other agencies:** | | | | | |
| ☐ Housing | ☐ Weatherization | ☐HEAP | ☐ Food Stamps | ☐WIC | ☐OWF |
| ☐CSB | ☐ HMG | ☐BVR | ☐ BCMH | ☐ SSI/Adult | ☐SSI/Child |

| | | |
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| **Medical Home: Y N** | **Medicaid/HMO: Y N** | **Insurance Provider:** |
| **Dental Home: Y N** | **Private Ins/HMO: Y N** | **Insurance Provider:** |
| **Child will be age eligible for the following next fall:** ☐ Kindergarten ☐ Head Start ☐Early Head Start | | |

_____

Parent/Guardian Signature Date

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Family Support Specialist/Home Visitor Signature Date

**Status:** Support Supervisor Initials_____ Date _____ Accepted ☐ Reconsider ☐ Not eligible ☐