CHILDCARE REFERRAL INTAKE FORM

***Required Information**

***Type of call:** ☐ Referral ☐ Repeat Referral ☐ Information/Consultation ☐ Protective Services Authorization

Intake Date: _____ **Date entered in database:** _____

Follow-up: Call ☐ Email ☐ Mailed ☐ Other _____

***Where did caller hear about service?** _____

PARENT INFORMATION:

Gender:** ☐ Male ☐ Female ☐Other ***Date of Birth:**_____State Employee ID# (if applicable):**_____

***Name:** _____

***Mobile Phone:** _____ ***Home Phone:** _____ **Work Phone:** _____

***Email:** _____

***Physical Address:** _____

***City:** _____ ***State:** _____ ***Zip:** _____

***Mailing Address (if different than Physical Address):** _____

***City:** _____ ***State:** _____ ***Zip:** _____

***County:** _____

Employer: _____

Work Address/Location: _____

Spouse/Partner Name: _____

Spouse/Partner Employer: _____

IF A COMMUNITY SERVICE PROVIDER IS CALLING OR FILLING THIS OUT FOR A PARENT:

***Name of Provider:** _____ ☐ **Protective Services Authorization**

***Service Agency:** _____ ***Contact Phone:** _____

***Email:** _____

***Contact Address:** _____

***City:** _____ ***State:** _____ ***Zip:** _____

***How did you hear of the service?** _____

***Required Information**

CHILD INFORMATION:

***Child Name (first/last):** _____ ***Gender:** Male ☐ Female ☐ Other ☐

***Age:** _____ ***Date of Birth:** _____ **Preferred Setting:** Licensed ☐ Registered ☐

***Date Needing Care:** _____ ***Schedule:** Full Time ☐ Part Time ☐ School Age ☐

Hours Needing Care:** _____ A.M._____ P.M.Days Needing Care:** M ☐ T ☐ W ☐ Th ☐ F ☐ Sa ☐ Sun ☐

***Child Name (first/last):** _____ ***Gender:** Male ☐ Female ☐ Other ☐

***Age:** _____ ***Date of Birth:** _____ **Preferred Setting:** Licensed ☐ Registered ☐

***Date Needing Care:** _____ ***Schedule:** Full Time ☐ Part Time ☐ School Age ☐

Hours Needing Care:** _____ A.M._____ P.M.Days Needing Care:** M ☐ T ☐ W ☐ Th ☐ F ☐ Sa ☐ Sun ☐

***Child Name (first/last):** _____ ***Gender:** Male ☐ Female ☐ Other ☐

***Age:** _____ ***Date of Birth:** _____ **Preferred Setting:** Licensed ☐ Registered ☐

***Date Needing Care:** _____ ***Schedule:** Full Time ☐ Part Time ☐ School Age ☐

Hours Needing Care:** _____ A.M._____ P.M.Days Needing Care:** M ☐ T ☐ W ☐ Th ☐ F ☐ Sa ☐ Sun ☐

ADDITIONAL INFORMATION:

***Towns looking for care in / Proximity (in miles) from home or work:** _____

***Child's Special Needs:** _____

***Primary Language:** _____

Reason needing care:

☐ Employment ☐ Developmental Growth

☐ Family Support ☐ Job Search

☐ Protective Service ☐ School/College

☐ Self Employed ☐ Health Need/Disability - Child

☐ Health Need/Disability - Adult

***Other Needs:** ☐ No Pets ☐ Smoke Free ☐ Allergies ☐ Asthma ☐ Diet ☐ Other: _____

Other Referrals Interested In Receiving Information About:

- ☐ ECFMH ☐ Community Action ☐ Dr. Dynasaur ☐ Early Intervention ☐ Family Support
- ☐ Childcare Financial Assistance Program ☐ Head Start ☐ Medicaid
- ☐ Other: _____

Comments: (Schools, transportation, counseling, desire to keep children together)

_____

Current Provider (if applicable): _____