

PA Pre-K Counts Partnership of Fayette

Family Application

492 COOLSPRING ROAD
 UNIONTOWN, PA 15401
 Phone: 724-437-2590 x 234

Fax: 724-437-8159

Application Date: _____

Program Year: _____

General Information – PRIMARY ADULT: (Please PRINT CLEARLY all information)																																													
Last Name:			First Name:			Middle:		Suffix:																																					
Primary Adult Living Address					City	State	Zip	County																																					
Primary Adult Mailing Address (if different)					City	State	Zip	Date of Birth																																					
Phone Number		Type: Home, Work, Cell, etc.		Primary	Notes																																								
				<input type="checkbox"/>																																									
				<input type="checkbox"/>																																									
				<input type="checkbox"/>																																									
Number in Household _____			Num. in Family _____		Total Num. of Children _____		Num. Age 3-5 _____																																						
Parental Status <input type="checkbox"/> One <input type="checkbox"/> Two			Primary Language at Home <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other Specify: _____																																										
Family Income					<i>Agency staff will complete shaded boxes.</i>																																								
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:25%;">Family Member</th> <th style="width:25%;">Income Source</th> <th style="width:10%;">Amount</th> <th style="width:5%;">Per</th> <th style="width:10%;">Annual Amount</th> <th style="width:5%;">Type¹</th> <th style="width:5%;">Desc.²</th> <th style="width:5%;">Verif.³</th> <th style="width:10%;">Staff Initials</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> <td style="text-align: center;">\$</td> <td style="background-color: #e0e0e0;"></td> <td style="background-color: #e0e0e0;"></td> <td style="background-color: #e0e0e0;"></td> <td style="background-color: #e0e0e0;"></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td style="text-align: center;">\$</td> <td style="background-color: #e0e0e0;"></td> <td style="background-color: #e0e0e0;"></td> <td style="background-color: #e0e0e0;"></td> <td style="background-color: #e0e0e0;"></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td style="text-align: center;">\$</td> <td style="background-color: #e0e0e0;"></td> <td style="background-color: #e0e0e0;"></td> <td style="background-color: #e0e0e0;"></td> <td style="background-color: #e0e0e0;"></td> </tr> </tbody> </table>										Family Member	Income Source	Amount	Per	Annual Amount	Type ¹	Desc. ²	Verif. ³	Staff Initials					\$									\$									\$				
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1. Type Codes ERN–Earned SUB–Subsidized (not from a wage)			2. Description Codes PEN–Pension SSI–SSI SS–Social Security SSD–Social Security Disability			3. Verification Codes CS–Check Stub W2–W-2 EL–Employer Letter DL–Determination Letter TR–Tax Return																																							
Income Notes																																													
Emergency Contacts																																													
Contact 1	Name			Relationship to Child			<input type="checkbox"/> Emergency Contact		<input type="checkbox"/> Release Child to																																				
	Address					City	State	Zip																																					
	Phone 1 Notes		Type /	Phone 2 Notes		Type /	Phone 3			Type / Notes																																			
Contact 2	Name			Relationship to Child			<input type="checkbox"/> Emergency Contact		<input type="checkbox"/> Release Child to																																				
	Address					City	State	Zip																																					
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Contact 3	Name			Relationship to Child			<input type="checkbox"/> Emergency Contact		<input type="checkbox"/> Release Child to																																				
	Address					City	State	Zip																																					
	Phone 1 Notes		Type /	Phone 2 Notes		Type /	Phone 3			Type / Notes																																			
Doctor/Dentist																																													
Doctor Name			Address			City	State	Zip	Phone																																				
Dentist Name			Address			City	State	Zip	Phone																																				

Certification: I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent/Guardian Signature _____

Date _____

Verifying Staff Member _____

Date _____

Family Member Information

Primary/Legal Guardian Adult					
Last	First	Middle	Preferred	Gender	
Birthdate	Relationship to Child: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Grandparent <input type="checkbox"/> Guardian <input type="checkbox"/> Other: _____				
Race (check all that apply) <input type="checkbox"/> American Indian or Alaska native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Island <input type="checkbox"/> White	Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	Highest Grade Completed	Employment Status ¹	<input type="checkbox"/> Lives with this Family <input type="checkbox"/> Provides Financial Support <input type="checkbox"/> Teen Parent (18 yrs or younger) <input type="checkbox"/> Incarcerated Parent	
		Email Address: _____			
Secondary Adult					
Last	First	Middle	Preferred	Gender	
Birthdate	Relationship to Child: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Grandparent <input type="checkbox"/> Guardian <input type="checkbox"/> Other: _____				
Race (check all that apply) <input type="checkbox"/> American Indian or Alaska native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Island <input type="checkbox"/> White	Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	Highest Grade Completed	Employment Status ¹	<input type="checkbox"/> Lives with this Family <input type="checkbox"/> Provides Financial Support <input type="checkbox"/> Teen Parent (18 yrs or younger) <input type="checkbox"/> Incarcerated Parent	
		Email Address: _____			
Secondary Adult Living Address (if not living with applicant) City _____ State _____ Zip _____ County _____					

Other Family Members					
Adult/Child	Last	First	Birthdate	Gender	Relationship
Notes					
1. Employment Status Codes: F - Full Time, P - Part Time, R - Retired or Disabled, T - Training or School, B - Full Time & Training, I - Part Time & Training, S - Seasonally Employed, U - Unemployed					

Agency Referral: _____

School district you live in: _____

Home Elementary School: _____

NOTICE: "All meals served to children under the Child Care Food Program are served at no separate charge regardless of race, color, sex, age, handicap, or national origin. There is no discrimination in admissions policy, meal service, or use of facilities. "Any complaints of discrimination should be submitted in writing within 180 days, of the incident to the Secretary of Agriculture, Washington, DC 20250." Information from this application will be used for ongoing reporting/monitoring and assessment on a secured web-based system that is shared with multiple agencies (i.e. OCDEL, Head Start, CCIS, and Early Intervention).

Child Information

Site Applying For:	<input type="checkbox"/> Cub's Den <input type="checkbox"/> D.Ferd Swaney Elementary School <input type="checkbox"/> Duck Hollow Discovery Learning Center <input type="checkbox"/> Kooser Group Home, Hatfield Lane	<input type="checkbox"/> Masontown Elementary School <input type="checkbox"/> Menallen Elementary School <input type="checkbox"/> Wharton Elementary School		
Last	First	Middle	Preferred	Suffix
Address		City		
Birthday	Gender	Verification of Birth		
		<input type="checkbox"/> Birth Cert. # _____ State: _____ Verified by: _____ Title: _____		
Race (check all that apply)		Ethnicity	English Proficiency	
<input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Island <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unspecified		<input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Mexican/Chicano	<input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient <input type="checkbox"/> Primary Other Language Spoken: _____ <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient <input type="checkbox"/> Primary	
Check if you have any of the following concerns regarding your child: <input type="checkbox"/> Speech <input type="checkbox"/> Behavioral <input type="checkbox"/> Developmental <input type="checkbox"/> Physical <input type="checkbox"/> Health <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Other: _____ Please Explain (optional): _____ Does this child have an active IEP or Behavior Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide.		Primary Health Coverage Source:		
		<input type="checkbox"/> Private <input type="checkbox"/> CHIP <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Medical Assistance		
Have you applied with Pre-K Counts or Head Start for this child? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, Year: _____ Is this child in childcare? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, where? _____ Is anyone in the household enrolled in child care, private school or college/university? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, who is enrolled? _____ Is there a custody agreement regarding this child? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please provide. Is this child under the care of a physician? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, why?		Health Information		
		Child's Birth Weight: _____ Immunizations Up-to Date? <input type="checkbox"/> No <input type="checkbox"/> Yes Does your Child have a physician they see regularly: <input type="checkbox"/> No <input type="checkbox"/> Yes Does your Child have a dentist they see regularly? <input type="checkbox"/> No <input type="checkbox"/> Yes		
How often do family members read to your child? <input type="checkbox"/> At least once day <input type="checkbox"/> At least once a week <input type="checkbox"/> At least once a month <input type="checkbox"/> Less than once a month How many children' books are in your home? <input type="checkbox"/> 0-5 <input type="checkbox"/> 5-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> More than 20				
Is this child income eligible for HS/EHS? Yes No		Primary Site:		

Computer: _____
Initial & date

Verified Disability: _____
Initial & date