Community Child Care Clearinghouse OF NIAGARA

Parent Intake Form

Revised: 12/1/2017

Referral Pkt:
IT Brochure (IT = Infant Toddler)
Safe Sleep (SIDS) – under 1 year
CC book – Infant Toddler booklet
CC book – Age 3 to 5 booklet
CC book – School Age booklet
No information sent – see comments

Referred to:
Head Start
Referred to WIC Program

Follow-up:
Left Message: _____
E-mail Sent: _____
No Answer: _____
Attempted: _____
Completed: _____
Secured Day Care: Y N
Secured SACC: Y N N/A

Date: _____ **Referral Specialist:** C. Jacobs **Family ID #:** _____

Regular Referral:	**New Client**	**Previous Client Same Quarter**	**Previous Client New Quarter**	**Not a New Request**
Online Referrals:	**Online Request – referrals received** **New** **Previous New Qtr** **Previous Same Qtr**	**Online Request – no referrals received** **(Permission not granted)**	**Permission received to process application** **Yes** **No**	**DO NOT COUNT as an online referral** **NOT a new online request**

Date Referrals:	**Mailed**	**E-mailed**	**Faxed**	**Office Pick-up**	**Time of Application**	**Call Back**	**Online**
	_____	_____	_____	_____	_____	_____	_____

Comments: _____

Name: _____
Address: _____ Apt: _____
City/Zip: _____ Employer/School: _____
Home Phone: _____ Address: _____
E-mail: _____
# of Children (seeking care for): _____ Work Phone: _____
Household: _____ Work Fax: _____
Date Care Needed to Start: _____ Relation to Child: _____

FAMILY COMPOSITION

Single Parent
Two Parent
Foster/Guardian
Teen Parent
Homeless/In Shelter
Grandparent/Other Relative
No Information
Caller Declined to Answer
Other: _____
Immigrant
Refugee
Asylum Seeker
Domestic Violence
Military

REASONS FOR SEAKING

End Leave of Absence
Employment
Education/Training
Relocation/Moved
Parent Non-Job Related Needs
Current Provider no Longer Available
Dissatisfied With Current Care
Other:
Child Expelled from Care
Seeking Employment
Child Development
Not Able to Determine

REFERRED BY

Child Care Provider
Local DSS
Public Agency
Relative/Friend
Social Media
Former Client
Internet/CCR&R Website
Community Visibility Event
Other: _____
Media/Newspaper
Phone Book
Private Agency/CBO
Employer
Regional 211
Health Care Professional

LOCATION OF CARE:

Near Home
Near Work/School/Training
Near Child's School
Near Public Transportation
In Own Home

SUBSIDY ELIGIBLE: Are you receiving child care subsidy or public assistance? Yes No

200% BELOW NYS Poverty
120% BELOW County eligibility
Receiving Child Care Subsidy
NOT Receiving Child Care Subsidy
On Waiting List for County Child Care Subsidy
Not Eligible for County Child Care Subsidy
Above 200% Poverty
Referred to NPA Child Care (716-439-7656)

CENSUS BUREAU QUESTIONS:

Is this person Spanish/Hispanic/Latino?
Did not answer Not Spanish/Hispanic/Latino Puerto Rican Mexican, Mexican American, Chicano Cuban Other:

What is this person's race?
Did not answer Black/African American White American Indian/Alaska Native Chinese Other:

Does this person speak a language other than English at home? Yes No If yes, language spoken: _____
How well does this person speak English? Very Well Well Not Well Not at all

Name: _____ **Sex:** F M U **Birth Date:** _____ **Age:** _____

Days of Care: Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Hours of Care: _____ TO: _____

TYPE OF CARE:
Child Care Center
Family Child Care
Group Family Child Care
Day Camp
School Age Program
Preschool Program

CARE NEEDED:
Full Time (30 plus hours)
Part Time (less than 30 hours)
Both

YEAR SCHEDULE:
Full Year Part Year
Summer Only

EXTRA CARE SERVICES
Drop-in (occasional & less than full day)
24-Hour
Temporary/Emergency (short notice during emergency to child not enrolled)
Before School
After School
Sick Care
Rotating (schedule changes weekly)

ENVIRONMENT:
No Pets
Peanut Free
Tree Nut Free
Smoke Free during non-business hours
Smoking during non-business hours

ADDITIONAL CARE SERVICES:
Evening Weekend
Overnight Snow Days
Mildly Ill/Sick
Part Week
Breast Feeding Friendly Certified
Extended Hours
Flexible Hours
Early Day/Morning
Late Day/Afternoon
Respite Care
Certified Breast Feeding

Language if other than English:
_____

SPECIAL SERVICES:
No Special Services Required
Behavior/Emotional
Development Disability
Educational Disability
Wheel Chair Accessible
Special Diet (state issue in comments)
Orthopedic Impairment
Seizure Disorder
Asthma
ADHD
Transportation
Speech/Language Impairment
Moderate Ill Health Service
Autism Spectrum Disorder
Visual Impairment
Diabetes
Itinerant/Visiting Specialist
Sign Language
Traumatic Brain Injury
Cerebral Palsy
Deafness/Other Hearing Impairment
Down Syndrome
Intellectual Disability
Other (state issue in comments)

TYPE OF PROGRAM REQUESTED:
Early Head Start
Head Start
Nursery School
Kindergarten
Universal Pre-K
Pre-K/Pre-school program
SACC
Summer Recreation
Playgroup
Special Interest
Montessori
Vacation/Holiday
Faith Based
Gifted
Inclusive/Special Education
Infant/Toddler Program

SCHOOL CHILD ATTENDS: _____

Medical Care Needs:
- MAT Trained
- No Preference

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