

Parent Interview Date _____ (Staff Only)

Name of Educare Program _____ (Staff Only)

PRENATAL PROGRAM INTAKE APPLICATION

APPLICANT - Pregnant Mom							
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN
Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency		
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> None		<input type="checkbox"/> Poor		
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Little		<input type="checkbox"/> Moderate		
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> Moderate		<input type="checkbox"/> Proficient		
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient				
Highest Grade Completed		Employment Status		Current Trimester	Answer all that apply	Check all that apply:	
<input type="checkbox"/> Associate's	<input type="checkbox"/> Grade 10	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full Time & Training	<input type="checkbox"/> First	Have you been pregnant before?	<input type="checkbox"/> First Pregnancy	
<input type="checkbox"/> Bachelor's	<input type="checkbox"/> Grade 11	<input type="checkbox"/> Part Time	<input type="checkbox"/> Part Time & Training	<input type="checkbox"/> Second		<input type="checkbox"/> Teen parent	
<input type="checkbox"/> Col Deg/Train	<input type="checkbox"/> Grade 12	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Training or School	<input type="checkbox"/> Third	If so, how many times?	<input type="checkbox"/> Receiving dental care	
<input type="checkbox"/> Col or Adv Train	<input type="checkbox"/> < Grade 9	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired or Disabled	Delivery Date: _____		<input type="checkbox"/> Currently receiving Prenatal Care	
<input type="checkbox"/> GED	<input type="checkbox"/> HS Graduate					<input type="checkbox"/> Currently Breast Feeding	
	<input type="checkbox"/> Master's					Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	
						Do you live with anyone who smokes? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email Address: _____							

Your Primary Support Person / Emergency Contact							
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN
Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency		
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> None		<input type="checkbox"/> Poor		
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Little		<input type="checkbox"/> Moderate		
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> Moderate		<input type="checkbox"/> Proficient		
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient				
Highest Grade Completed		Employment Status		Child's Relationship	Future custody	Check all that apply:	
<input type="checkbox"/> Associate's	<input type="checkbox"/> Grade 10	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full Time & Training	<input type="checkbox"/> Biological/Adopted/Step	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Lives with Applicant	
<input type="checkbox"/> Bachelor's	<input type="checkbox"/> Grade 11	<input type="checkbox"/> Part Time	<input type="checkbox"/> Part Time & Training	<input type="checkbox"/> Grandchild		<input type="checkbox"/> Supported by Applicant	
<input type="checkbox"/> Col Deg/Train	<input type="checkbox"/> Grade 12	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Training or School	<input type="checkbox"/> Niece/Nephew		<input type="checkbox"/> Related to unborn child by blood or marriage to applicant	
<input type="checkbox"/> Col or Adv Train	<input type="checkbox"/> < Grade 9	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Other		<input type="checkbox"/> Teen parent	
<input type="checkbox"/> GED	<input type="checkbox"/> HS Graduate			Expectant Father <input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Master's						
Email Address: _____							

Do you have other children? If NO → Skip to next section. If yes, fill out this section →

Additional Child

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN
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Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> Yes	<input type="checkbox"/> None		<input type="checkbox"/> Poor
<input type="checkbox"/> Black	<input type="checkbox"/> No	<input type="checkbox"/> Little		<input type="checkbox"/> Moderate
<input type="checkbox"/> White		<input type="checkbox"/> Moderate		<input type="checkbox"/> Proficient
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Proficient		

Is this child currently enrolled in an Educare program?

Additional Child

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN
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Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> Yes	<input type="checkbox"/> None		<input type="checkbox"/> Poor
<input type="checkbox"/> Black	<input type="checkbox"/> No	<input type="checkbox"/> Little		<input type="checkbox"/> Moderate
<input type="checkbox"/> White		<input type="checkbox"/> Moderate		<input type="checkbox"/> Proficient
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Proficient		

Is this child currently enrolled in an Educare program?

Additional Child

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN
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Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> Yes	<input type="checkbox"/> None		<input type="checkbox"/> Poor
<input type="checkbox"/> Black	<input type="checkbox"/> No	<input type="checkbox"/> Little		<input type="checkbox"/> Moderate
<input type="checkbox"/> White		<input type="checkbox"/> Moderate		<input type="checkbox"/> Proficient
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Proficient		

Is this child currently enrolled in an Educare program?

Please place a check next to the following statements which best applies to you or your children:

- Have you or any of your children been diagnosed with a disability (have an IEP/IFSP)?
- Do many of your children have a potential, suspected, or prior diagnosed disability?
- Do you or any of your children have health issues (allergies, asthma, anemia, obesity, diabetes, other chronic issue)?
- Do you or did you have any high-risk birth factors for your other children (late prenatal care, low birth weight, premature)?
- Have you ever delivered a preterm baby before (less than 37 weeks gestation)? If yes, how many? ____

Family Information, Income & Contacts

Family Information							
Living Address	Address Line 2	Zip	City	State	Ward		
Mailing Address (if different)	Address Line 2	Zip	City	State	Ward		
<p>Please list additional family members who live in the home, supported by parent/guardian's income and related by blood, marriage or adoption.</p> <p>1.</p> <p>2.</p> <p>3.</p>							
Phone Numbers	Type (check one)			Note (for example, an extension or best time to call)			
	<input type="checkbox"/> Cell	<input type="checkbox"/> Home	<input type="checkbox"/> Work	<input type="checkbox"/> Other			
	<input type="checkbox"/> Cell	<input type="checkbox"/> Home	<input type="checkbox"/> Work	<input type="checkbox"/> Other			
	<input type="checkbox"/> Cell	<input type="checkbox"/> Home	<input type="checkbox"/> Work	<input type="checkbox"/> Other			
Parental Status (check one)	Primary Language at Home	Homeless Family	Active Duty Military	Referred by Child Welfare Agency	Receiving SNAP	WIC	WIC ID (if applicable)
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Family Income			
TANF	Supplemental Security Income		Total Numbers of Household Members Supported by Income and Related by Blood, Marriage or Adoption
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Formerly	<input type="checkbox"/> Yes <input type="checkbox"/> No		_____

Pregnant Mom Signature _____

Date _____