



APPLICATION

Date of Application: _____ Anticipated Start Date: _____

Child's Name: _____

Nickname: _____

Child's SSN: _____ Date of Birth: _____

Mother's Name: _____

Mother's Address: _____

Mother's Contact Number(s): Hm: () _____ Cell: () _____

Mother's Employer: _____

Mother's Work Number: () _____

Father's Name: _____

Father's Address: _____

Father's Contact Number(s): Hm: () _____ Cell: () _____

Father's Employer: _____

Father's Work Number: () _____

Mother/Father's Email: _____

Please list all names, relationships and ages of people living in the child's home. Additional names can be added on back of page.

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Referred by: _____

Funding Source: Private Pay ABC Voucher ABC Special Needs DDSN

Do you need transportation? No Yes

Child's Development and Health History

Physical Health:

Has your child had any health issues in the past? No Yes If yes, please explain _____

Does your child have any health issues now? _____

Does your child have any recurring chronic illness or health problems (such as asthma or frequent earaches)? No Yes if yes, please list

Does your child have a diagnosed disability (such as cerebral palsy, seizure disorder, autism)? No Yes if yes, please list

Do you have any other concerns about your child's health? No Yes if yes, please explain

Describe your child's development compared to other children his/her age:

Does your child have any issues with talking or making sounds? No Yes if yes, please explain

Does your child have any issues with walking, running or moving? No Yes if yes, please explain

Does your child have any problems with hearing or vision? No Yes if yes, please explain.

Does your child have any problems using his/her hands (such as with puzzles, drawing, small building pieces)? No Yes if yes, please explain.

Daily Living:

Does your child take a bottle? No Yes

What type of formula do you use? _____

What amount of formula is given? _____

Should the bottle be warmed? No Yes

Does your child hold his/her own bottle? No Yes

Does your child eat food? No Yes

What type of food? Baby Food Table food Other _____

Does your child have any special feeding needs? Please explain _____

What food does your child like? _____

What food does your child dislike? _____

Does your child toilet independently? No Yes

Does your child use diapers pull-ups NA

How does your child indicate bathroom needs? _____

Does your child have any special toileting needs? No Yes if yes, please explain

What is your child's regular sleeping pattern? Awakes at _____. Naps at _____.

How does your child sleep (on his/her back or stomach)? _____

How does your child like to go to sleep (i.e. rocking, cuddling, a blanket)? _____

Social Relationships/Play

What ages are your child's most frequent playmates? _____

Does your child play well alone? No Yes

What is your child's favorite toy? _____

What is the most effective way to discipline your child? _____

Who does the most disciplining in your family? _____

With what adults does your child have frequent contact? _____

How do you comfort your child? _____

Does your child have a special comforting item? No Yes if yes, please list _____

What else should we know about your child?

We greatly appreciate you taking the time to complete this application as thoroughly as possible.
This information will help us best serve you and your child.

Feel free to add additional pages if you need more space to share information.