# Child Care Referral Client Intake Form

**DATE:**   **CLIENT ID#** *(office use only)****:***

**NAME:**

**ADDRESS (Location):** **Zip**

**COUNTY WHERE YOU RESIDE: ** Cortland County **** Tompkins County

**MAILING ADDRESS** (*if different from above)****:***

**HOME PHONE:**   **WORK PHONE:**

**CELL PHONE:**  **E-MAIL ADDRESS:**

#### FAMILY COMPOSITION:  Single Parent  Two Parent  Teen Parent  Grandparent/Other Relative

####   Foster/Guardian  Other:  Declined to answer

**EMPLOYER(S):**

#

#

# LOCATION OF CARE NEAR:  Near Home  Near Work/School/Training

#   Near Child’s School  Near Public Transportation

#

|  |
| --- |
| CHILDREN NEEDING CARE |
| Name | *Date of Birth* | *Date Care Needed* |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| SCHEDULE | Start Time | *End Time* |
| Monday |  |  |
| Tuesday |  |  |
| Wednesday |  |  |
| Thursday |  |  |
| Friday |  |  |
| Saturday |  |  |
| Sunday |  |  |

**TYPES OF CARE: ** Child Care Center **** Family Daycare **** Group Family Daycare

 **** School Age Program **** OCFS Regulated Summer Camp

**CARE NEEDED:** **** Full Time **** Part Time **** Both **SCHEDULE:** **** Full Year **** School Year **** Summer Only

**LOOKING FOR CARE IN: ** Cortland County **** Tompkins County **** Both Cortland and Tompkins Counties

**EXTRA CARE SERVICES:**

**** Drop In **** 24-Hour **** Before School **** After School **** Half Day

**** Temp/Emergency **** Evening **** Overnight **** Weekend **** Snow Days

**** Mildly Ill/Sick **** Respite Care **** Rotating Schedule **** Breast Feeding Friendly

**** Breast Feeding Friendly Certified *(only Child Adult Care Food Program providers can get this)*

**LANGUAGES:**  English  Spanish  American Sign Language  Other:

# SPECIAL NEEDS:

Developmental Disability Educational Disability Moderately Ill/Health Service  Sign Language Medical Care Needs Wheelchair Access Autism Spectrum Disorder ADHD

Cerebral Palsy Deafness or Other Hearing Impairment Down Syndrome Intellectual Disability Speech or Language Impairment Visiting Specialist Traumatic Brain Injury Visual Impairment Transportation Special Diet Behavioral/Emotional  Other

**MEDICATION ADMINISTRATION TRAINING (MAT):**

**** NYS approved to give medication **** Not NYS approved to give medication

**PROGRAM:**

 Nursery School  Play Group  Kindergarten  Inclusive/Special Education

 Vacation/Holiday  Special Interest  Summer Recreation  SACC (School Aged Child Care)

 Half Day  Montessori  Faith Based  Universal Pre-K

#  Pre-K/Preschool  Early Head Start  Head Start

**ELEMENTARY SCHOOL(S) and GEOGRAPHIC AREAS:**

**Tompkins County:**

 Belle Sherman  Beverly J Martin  Caroline  Cayuga Heights  City of Ithaca  Dryden

 East Hill  Enfield  Fall Creek  Freeville  Groton  Lansing

 McLean  Newfield  Northeast  South Hill  Trumansburg  West Hill

# Cortland County:

 Appleby  Barry  Cinncinnatus  DeRuyter  Fabius Pompey  Hartnett

 Homer  McGraw  Parker  Randall  Smith  Virgil

# INCOME:  Above NYS 200% of Poverty  Below NYS 200% of Poverty

# FAMILY SIZE: ADULTS:  Single Adult in Household  Two or More Adults in Household

# HOW DID YOU HEAR ABOUT US?

****Child Care Provider ****LDSS ****Other Public Agency ****Private Agency/CBO ****Relative/Friend ****Employer ****Phone Book ****Media/Newspaper ****Former Client ****Regional 211 ****Other *(see box below)* ****Council Facebook page

****Social Media ****Community Visibility Event ****Internet/CCR&R Website

**REASON(S) FOR SEEKING CARE:**

**** End Leave of Absence **** Seeking Employment **** Employment

**** Training/Education **** Child’s Development **** Parent’s Non-Job Related Needs

**** Dissatisfied with Care **** Relocation/Moved **** Current Provider No Longer Available

**** Other:

|  |
| --- |
| **ADDITIONAL COMMENTS FOR THE REFERRAL SPECIALIST:** |