CHILD CARE RESOURCE NETWORK
CLIENT INTAKE FORM

CLIENT ID: _____

*** Highlighted fields must be filled out to receive a referral.**
Fill out both sides of form then send email to parentservices@wnychildren.org
You can also call us at 877-6666 ext. 3064 to do a referral over the phone

DATE: _____ **REFERRAL SPECIALIST:** _____

CLIENT INFORMATION

CLIENT NAME: _____

NAME: (If not parent) _____ **AGENCY: (If caseworker)** _____

I AM THE: ☐ MOTHER ☐ FATHER ☐ FOSTER PARENT* ☐ GRANDPARENT ☐ CASEWORKER

☐ GUARDIAN ☐ OTHER: _____

HOUSEHOLD: ☐ SINGLE PARENT ☐ 2 PARENT ☐ GRANDPARENT/OTHER RELATIVE ☐ TEEN PARENT

☐ FOSTER PARENT ☐ OTHER: _____

LANGUAGE SPOKEN IN HOME: ☐ ENGLISH ☐ OTHER: _____

PHONE NUMBER: _____ CELL ☐ HOME ☐ WORK ☐ TEXT OK ☐

EMAIL: _____

ADDRESS: _____ apt._____

CITY: _____ **ZIP:** _____

OTHER ADDRESS: (If you want care near another address, such as work, school etc.) _____

_____

CARE NEEDED NEAR: ☐ HOME ☐ WORK/SCHOOL/TRAINING ☐ PUBLIC TRANSPORTATION

REASON YOU ARE LOOKING FOR CARE: ☐ JOB ☐ LOOKING FOR A JOB ☐ SCHOOL/TRAINING ☐ END LEAVE OF ABSENCE ☐ OTHER_____

RECEIVING SUBSIDY/Downtown helping pay for Care: ☐ YES ☐ NO

How did you hear about us: ☐ PROVIDER ☐ DSS ☐ OTHER AGENCY ☐ RELATIVE/FRIEND ☐ EMPLOYER ☐ 211 ☐ INTERNET/CCRN WEBSITE ☐ HEALTHCARE PROFESSIONAL ☐ OUTREACH EVENT ☐ RADIO/TV ☐ SCHOOL DISTRICT/STAFF ☐ NO INFORMATION ☐ OTHER:_____

CHILD INFORMATION

DATE CARE NEEDED: ☐ NOW ☐ DATE: _____

BIRTHDATE: _____ **BIRTHDATE:** _____ **BIRTHDATE:** _____

BIRTHDATE: _____ **BIRTHDATE:** _____ **BIRTHDATE:** _____

TYPE OF CARE: ☐ CENTER ☐ FDC ☐ GFDC ☐ SACC ☐ CAMP

MEDICATION NEEDED DURING CARE: ☐ NO ☐ YES

SPECIAL NEEDS: (If you know) ☐ NO ☐ YES: _____

TRANSPORTATION: ☐ NO ☐ PROVIDED ☐ IT WOULD BE NICE ☐ PROVIDED BY SCHOOL DISTRICT

DAYS OF WEEK: ☐ Mon-Fri ☐ Sat ☐ Sun **TIMES:** _____AM / PM - TO _____AM/PM

CARE NEEDED: ☐ FULL TIME ☐ PART TIME ☐ FULL YEAR ☐ SCHOOL YEAR ☐ SUMMER