



School Readiness Program Wait List Application

<input type="checkbox"/>	ELIGIBLE
<input type="checkbox"/>	NOT ELIGIBLE

Today's Date _____

Primary Parent _____ **County** _____

Name _____ **Gender** Male Female

Race(s) Asian Black White Hawaiian/Pacific US Indian/Alaskan **Ethnicity** Hispanic Non-Hispanic

Marital Status Divorced Married Widowed Separated Single

Date of Birth (mm/dd/yyyy) _____/_____/_____

Social Security Number (optional) _____ **Medicaid Number** _____

Request For Assistance Number (RFA) _____

Are you Employed? Yes No **Do you work more than 20 hours a week?** Yes No

Are you a Student? Yes No **Are You a Migrant?** Yes No

Where Do You Live? Apartment House Shelter With Family/Friends

Do You Need a Translator? Yes No **Is Assistance Needed Due To a Disability?** Yes No

Mailing Address _____ **Physical Address** _____

City/Zip Code _____ **City/Zip Code** _____

Home Telephone _____ **Other Telephone** _____

E-Mail _____ **Number of Members in Household** _____

Employment Information

Employer Name _____

Address _____

City/State/Zip Code _____

Telephone _____ **E-Mail** _____

Gross Earnings _____ **Per** Hour Week Semi-Monthly Year

Non-Employment Based Income

Please check all that apply: Alimony Foster Care Food Stamps Housing Assistance Military Allotment Pension

Retirement Benefits Social Security Unemployment/Workers Compensation

Veteran's Benefits Wage Assistance Child Support Any Other Unearned Income

Gross Earnings _____ **Per** Hour Week Bi-Weekly Semi-Monthly Monthly Year

Would you like to have your child(ren)'s hearing checked? Yes No

Would you like to have your child(ren)'s vision checked? Yes No

Secondary Parent

Name _____ **Gender** Male Female

Race(s) Asian Black White Hawaiian/Pacific US Indian/Alaskan **Ethnicity** Hispanic Non-Hispanic

Marital Status Divorced Married Widowed Separated Single

Date of Birth (mm/dd/yyyy) _____/_____/_____

Social Security Number (optional) _____ **Medicaid Number** _____

Are you Employed? Yes No **Do you work more than 20 hours a week?** Yes No

Are you a Student? Yes No

Where Do You Live? Apartment House Shelter With Family/Friends

Do You Need a Translator? Yes No **Is Assistance Needed Due To a Disability?** Yes No

Employment Information

Employer Name _____

Address _____

Telephone _____ **E-Mail** _____

Gross Earnings _____ **Per** Hour Week Semi-Monthly Year

Non-Employment Based Income

Please check all that apply: Alimony Foster Care Food Stamps Housing Assistance Military Allotment Pension

Retirement Benefits Social Security Unemployment/Workers Compensation

Veteran's Benefits Wage Assistance Child Support Any Other Unearned Income

Gross Earnings _____ **Per** Hour Week Bi-Weekly Semi-Monthly Monthly Year

Child Information

Please Complete Both Sides of Application

Name _____ Gender Male Female
 Race(s) Asian Black White Hawaiian/Pacific US Indian/Alaskan
 Ethnicity Hispanic Non-Hispanic
 Date of Birth (mm/dd/yyyy) ____/____/_____
 Social Security Number (optional) _____
 Child's Medicaid Number _____
 Primary Parent's Relationship to Child Foster Care Guardian Parent/Step-parent Relative Other
 Does This Child Have Special Needs? Yes No
 Is This Child Currently Receiving Services? Head Start School Readiness Pre-K Speech Therapy Physical Therapy
 Mental Health Therapy Respiratory Therapy Other Don't Know

Child Information

Name _____ Gender Male Female
 Race(s) Asian Black White Hawaiian/Pacific US Indian/Alaskan
 Ethnicity Hispanic Non-Hispanic
 Date of Birth (mm/dd/yyyy) ____/____/_____
 Social Security Number (optional) _____
 Child's Medicaid Number _____
 Primary Parent's Relationship to Child Foster Care Guardian Parent/Step-parent Relative Other
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 Ethnicity Hispanic Non-Hispanic
 Date of Birth (mm/dd/yyyy) ____/____/_____
 Social Security Number (optional) _____
 Child's Medicaid Number _____
 Primary Parent's Relationship to Child Foster Care Guardian Parent/Step-parent Relative Other
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 Is This Child Currently Receiving Services? Head Start School Readiness Pre-K Speech Therapy Physical Therapy
 Mental Health Therapy Respiratory Therapy Other Don't Know

ELCNC -255 Rev. 2 9/13/11 This application is valid for **six months**. To renew your application, please contact a Parent Services Specialist.
Failure to renew your application will result in termination from the Wait List.

Parent Signature _____ Date _____

Chiefland Office
 212 N. Main Street
 Chiefland, FL 32626
 Phone: 352-490-5855
 Fax: 352-490-6762

Crystal River Office
 1566 N. Meadowcrest Blvd.
 Crystal River, FL 34429
 Phone: 352-563-9939
 Fax: 352-563-5933

Sumter Office
 114 N. Jumper Drive
 Bushnell, FL 33513
 Phone: 352-793-5430
 Fax: 352-793-6230