CHILD CARE REFERRAL REQUEST

HAVE YOU RECEIVED REFERRALS BEFORE? YES NO

1. NAME: ___________________________________________________
   ADDRESS ______________________________________CITY___________________ ZIP_____________
   PHONE _______________________

2. 1st Child’s age_____ 2nd Child’s age___ 3rd Child’s age___ 4th Child’s age___ 5th Child’s age___
   DOB _______ DOB_______ DOB_______ DOB_______ DOB_______

3. What days are needed for childcare? (Check all that apply)
   □ Monday-Friday and/or
   □ Mon □ Tue □ Wed □ Thurs □ Fri □ Sat □ Sun

4. Earliest expected drop-off time ____________________AM/PM
   Latest pick-up time _________________________AM/PM

5. What type of Child Care wanted: (Check all that apply)
   □ Center □ Family Day Care Home □ Drop in care as needed

6. Where would you like Child Care? (Check all that apply)
   Near home: _____________________________________________ (cross street)
   Near parent’s work/school/training: __________________________ (cross street)
   Near child’s school: _________________________________________ (cross street)

7. Reason why you need child care? (Check all that apply)
   □ Employment □ other parent needs □ school/training □ CPS
   □ Enrichment □ looking for work □ alternate/back up care

8. Language of service preferred: □ English □ Spanish □ Bilingual (Eng/Span)

9. Any special needs or request? __________________________________________________

10. How do you want to receive this referral?
    □ Mailed □ Pick up in office □ Fax □ E-mail ________________________________

   Name of person filling out this form _________________________ Date __________ Time _______
