

**GLEN COVE CHILD DAY CARE CENTER, INC. / HEAD START**

**P.O. BOX 191 Glen Cove, NY 11542 Telephone: 516-671-2880 Fax: 516-671-7401**

Application Date: \_\_\_\_\_

**CHILD'S INFORMATION**

Child's First Name \_\_\_\_\_ Child's Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security# \_\_\_\_\_ Place of Birth \_\_\_\_\_  
Does Child Have Health Insurance Yes \_\_\_\_\_ NO \_\_\_\_\_

**HEAD OF HOUSEHOLD**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Social Security \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_ Martial Status \_\_\_\_\_

Address \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

Employer's Name \_\_\_\_\_ #of days per week \_\_\_\_\_ # hours per day \_\_\_\_\_ Income \_\_\_\_\_

Direccion del trabajo \_\_\_\_\_

**SPOUSE INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Social Security# \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_ Martial Status \_\_\_\_\_

Address \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

Employer's Name \_\_\_\_\_ #of days per week \_\_\_\_\_ Hours \_\_\_\_\_ Income \_\_\_\_\_

Address \_\_\_\_\_

How did you hear about our program? \_\_\_\_\_

Do you receive TANF/SSI? \_\_\_\_\_

Are there any concerns about your child's development? \_\_\_\_\_

**HOUSEHOLD INFORMATION, PLEASE LIST ANYONE ELSE WHO RESIDES IN THE HOUSEHOLD.**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Relation to child \_\_\_\_\_

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