A.B.C.D. Inc. 1070 Park Ave., Bridgeport, CT 06604 **202-366-8241 ext. 225**

Please bring proof of income, child's birth certificate, child's social security card, Health insurance card, physical exam and immunizations when you return this application.

How did you hear about ABCD Child Care? _____

Section I – Eligible Child

Services needed: (check one) ☐ Full Day / Full Year 7;30 am-5:30 pm ☐ Part Day / Part Year 9:00 am –2:00 pm

Child's name: _____
First name MI Last name

Date of birth: ____/____/____ Place of Birth _____ **Gender:** ☐ M ☐ F

Address: _____
Street

_____
Town / City State Zip Code

Telephone: _____ **Other:** _____

Which area in Bridgeport do you live in : ☐ West Side ☐ East Side ☐ South End ☐ North End ☐ Hollow

Language(s) spoken: Primary: _____ Secondary: _____

English speaking ability: ☐ Very well ☐ Well ☐ Not well ☐ Not at all

Section II – Family Members

Do you receive any of the following types of assistance : ☐ Energy Assist. ☐ Medicaid Health Insurance ☐ Food Stamps

Primary supporting parent name: _____
(Head of Household) First name MI Last name

Relationship to child: _____

Person employed or in school (check all that apply):
☐ Employed
☐ In School
☐ Neither Employed or in School

Other supporting parent name: _____
First name MI Last name

Relationship to child: _____

Person employed or in school (check all that apply):
☐ Employed
☐ In School
☐ **Neither Employed or in School**

List names of all children, other family members and their ages:

_____

_____

I certify that the information provided in this application, is accurate and truthful to the best of my knowledge.

Parent / Guardian signature: _____

Confidentiality Statement: all information shared with the Child Care staff will be kept strictly confidential unless its release is in authorized writing. These forms will be maintained in locked files.

I would like to refer an eligible family to your program. Name: _____ Phone: _____

Rev1/04 ecn

For Office Use Only: Date Received: _____ **Staff Signature:** _____