

Intake Agency: _____

Date: _____

SPARK Innovation Zone Intake Form

First Name: _____ Last Name: _____ MI: _____ DOB: _____

Address: _____ Apt #: _____ City/State/Zip: _____

Home Number: (____) _____ - _____ Work Number: (____) _____ - _____ Cell Number: (____) _____ - _____

May we text your phone? Yes No Best time to call: Morning (8 AM – 12 PM) Afternoon (12 PM – 5 PM) Evening (5 PM – 8PM)

Email Address: _____ Primary language spoken: English Spanish Other: _____

Who can we contact if we cannot reach you using the above contact information?

Name: _____ Phone Number: (____) _____ - _____

Relationship: _____ Alt Number: (____) _____ - _____

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| Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Live-in partner <input type="checkbox"/> Widowed <input type="checkbox"/> Married | Health Insurance Coverage: <input type="checkbox"/> None <input type="checkbox"/> Military <input type="checkbox"/> Private (HMO, PPO) <input type="checkbox"/> Public: Medicaid/Medicare/AllKids | Highest Level of Education: <input type="checkbox"/> Elementary: Grade level <input type="checkbox"/> Some High School <input type="checkbox"/> High School Graduate/GED <input type="checkbox"/> Some College <input type="checkbox"/> College Graduate | Applicant Occupation: _____ Hours worked/wk: _____ Hourly pay: _____ Annual income: _____ Other Occupation: _____ Hours worked/wk: _____ Hourly pay: _____ Annual income: _____ |
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| Client's Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White or Caucasian <input type="checkbox"/> More than one race | Client's Ethnicity: Is client Hispanic or Latina/o? <input type="checkbox"/> Yes <input type="checkbox"/> No | Possible Referrals: <input type="checkbox"/> Child Care List <input type="checkbox"/> EI <input type="checkbox"/> CCAP <input type="checkbox"/> CSBG <input type="checkbox"/> PFA <input type="checkbox"/> WIC <input type="checkbox"/> Preschool Expansion <input type="checkbox"/> Two Rivers Head Start <input type="checkbox"/> Migrant Head Start <input type="checkbox"/> Home Visiting <input type="checkbox"/> Other _____ |
| | Currently Receiving: <input type="checkbox"/> WIC <input type="checkbox"/> CCAP <input type="checkbox"/> SSI/SSD <input type="checkbox"/> DCFS <input type="checkbox"/> SNAP <input type="checkbox"/> TANF <input type="checkbox"/> IFSP/IEP <input type="checkbox"/> Other | |
| | Transportation: <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Notes:

| Full Name | Birthdate | Relationship to Applicant | Attending Program | If YES, what program? | Developmental Screening? | If YES, what date? | If YES, where? |
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I agree to release information to SPARK Aurora Early Childhood Collaboration in order to assist in providing the most appropriate services for my family. I understand that I may be contacted if more information is needed. If referrals are needed, I give my permission to share my information with programs that provide those services, including the Kane County Home Visitation Collaborative, and I understand I may be contacted by staff from those programs.

Signature

Date