Section 4: Child Information **Complete this section for each child in your home

Last Name*:	First Name*:	Middle Initial:

Social Security Number (Optional): _____-_____-_____	Date of Birth (MM/DD/YYYY)*: ____/____/_____	Gender*: ☐ Male ☐ Female	Relationship to the Primary Adult Caretaker*:

Citizenship Status*: ☐Citizen ☐Non-citizen ☐ Qualified Alien	Race (optional, mark all that apply):	☐ American Indian or Alaskan Native ☐ Asian	☐ Black	☐ Native Hawaiian or Pacific Islander ☐ White	☐ Other	Ethnicity (optional): ☐ Hispanic ☐ Non-Hispanic

Is this a child who is part of a Joint Custody agreement or another case?*	☐ Yes ☐ No	Are you requesting care for this child?*	☐ Yes ☐ No
Is this child part of a foster custody arrangement?	☐ Yes ☐ No		

Immunization status: ☐Yes, Immunized ☐No, In Process ☐No, Religious Exemption ☐No, Medical Exemption

Is this child enrolled in a Head Start/Early Head Start Program? ☐ Yes ☐ No If yes, what is their enrollment start date and end date? Start:___/____/_____ End: ___/____/_____	Does this child have a disability or have additional care needs?*	☐ Yes ☐ No

If your child is receiving Medicaid, are you interested in a referral to a developmental screening for this child through Early and Periodic Screening Diagnosis and Treatment?	☐Yes ☐ No
If your child is not receiving Medicaid, are you interested in a referral to a developmental screening for this child through Part B or C of the Individuals with Disabilities Education Act?	☐Yes ☐ No

Section 4 Cont'd **Complete this section for each child in your home

Last Name*:	First Name*:	Middle Initial:

Social Security Number (Optional): _____-_____-_____	Date of Birth (MM/DD/YYYY)*: ____/____/_____	Gender*: ☐ Male ☐ Female	Relationship to the Primary Adult Caretaker*:

Citizenship Status*: ☐Citizen ☐Non-citizen ☐ Qualified Alien	Race (optional, mark all that apply):	☐ American Indian or Alaskan Native ☐ Asian	☐ Black	☐ Native Hawaiian or Pacific Islander ☐ White	☐ Other	Ethnicity (optional): ☐ Hispanic ☐ Non-Hispanic

Is this a child who is part of a Joint Custody agreement or another case?*	☐ Yes ☐ No	Are you requesting care for this child?*	☐ Yes ☐ No
Is this child part of a foster custody arrangement?	☐ Yes ☐ No		

Immunization status: ☐Yes, Immunized ☐No, In Process ☐No, Religious Exemption ☐No, Medical Exemption

Is this child enrolled in a Head Start/Early Head Start Program? ☐ Yes ☐ No If yes, what is their enrollment start date and end date? Start:___/____/_____ End: ___/____/_____	Does this child have a disability or have additional care needs?*	☐ Yes ☐ No

If your child is receiving Medicaid, are you interested in a referral to a developmental screening for this child through Early and Periodic Screening Diagnosis and Treatment?	☐Yes ☐ No
If your child is not receiving Medicaid, are you interested in a referral to a developmental screening for this child through Part B or C of the Individuals with Disabilities Education Act?	☐Yes ☐ No

COLORADO
Office of Early Childhood
Department of Human Services