

First 5 Ventura County Participation Form

Please complete ALL sections

FAMILY INFORMATION		Office use only					
		Site:		Program:		Family GEMS ID #	
Family Last Name		Home Phone Number			Alternate phone number		
Family Street Address			Apt. #	City		Zip code	
Family Size (including adults, circle one)		1 2 3 4 5 6 7+		Number of children in your household ages 0-5 years old (up to 6 th birthday)		1 2 3 4 5	
What language is spoken most often in your home?							
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Mixteco <input type="checkbox"/> Korean <input type="checkbox"/> Cantonese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Mandarin <input type="checkbox"/> Other _____							
Total FAMILY INCOME in the last 12 months							
<input type="checkbox"/> Less than \$10,000 <input type="checkbox"/> \$10,000 – less than \$20,000 <input type="checkbox"/> \$20,000 – less than \$30,000		<input type="checkbox"/> \$30,000 – less than \$40,000 <input type="checkbox"/> \$40,000 – less than \$50,000 <input type="checkbox"/> \$50,000 – less than \$75,000		<input type="checkbox"/> More than \$75,000 <input type="checkbox"/> No answer/prefer not to say			
Where does your family currently live? (check only one box) This information will be used to determine if your child qualifies for additional assistance under the "No Child Left Behind Act of 2001".							
<input type="checkbox"/> In a single family residence <input type="checkbox"/> With more than one family in a house or apartment due to economic hardship				<input type="checkbox"/> In a shelter or transitional housing program <input type="checkbox"/> In a motel, car or camp site <input type="checkbox"/> Foster care placement or group home			
How did you hear about this program? (Check all that apply)							
<input type="checkbox"/> Friend or family member <input type="checkbox"/> Online		<input type="checkbox"/> Neighborhood for Learning (NFL) <input type="checkbox"/> Flyer, brochure, etc. <input type="checkbox"/> Doctor or Nurse		<input type="checkbox"/> TV, newspaper or Radio <input type="checkbox"/> School or childcare provider		<input type="checkbox"/> Other _____ <input type="checkbox"/> No answer/prefer not to say	
Would you like to receive information about health insurance programs for your child/children?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you like to receive information about developmental check-up services for your child/children?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
ADULT #1		GEMS ID #		Office use only: Date Consent Signed ___/___/___			
Adult's First Name		Adult's Last Name		Adult's Mid. Initial		Adult's Date of Birth ____/____/____ Month /day /year	
Date of Registration ____/____/____				Adult's gender <input type="checkbox"/> Male <input type="checkbox"/> Female			
Cell Phone Number		Work Phone Number		Email			
What is your current employment status? <input type="checkbox"/> Unemployed <input type="checkbox"/> Employed part-time <input type="checkbox"/> Employed full-time <input type="checkbox"/> Seasonal worker <input type="checkbox"/> Temporary employment <input type="checkbox"/> Stay at home parent <input type="checkbox"/> No answer/prefer not to say		Are you a single parent? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No answer/prefer not to say		Family member type: <input type="checkbox"/> Parent <input type="checkbox"/> Expecting mother <input type="checkbox"/> Foster parent <input type="checkbox"/> Grandparent or other relative		Do you have a high school diploma or a GED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No answer/prefer not to say	
Adult's Ethnicity: (check only one)							
<input type="checkbox"/> Alaskan Native/American Indian <input type="checkbox"/> Pacific Islander		<input type="checkbox"/> Asian <input type="checkbox"/> White		<input type="checkbox"/> Black/African-American <input type="checkbox"/> Multiracial		<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Other _____	
ADULT #2		GEMS ID #		Office use only: Date Consent Signed ___/___/___			
Adult's First Name		Adult's Last Name		Adult's Mid. Initial		Adult's Date of Birth ____/____/____ Month /day /year	
Date of Registration ____/____/____ Month /day /year				Adult's gender <input type="checkbox"/> Male <input type="checkbox"/> Female			
Cell Phone Number		Work Phone Number		Email			
What is your current employment status? <input type="checkbox"/> Unemployed <input type="checkbox"/> Employed part-time <input type="checkbox"/> Employed full-time <input type="checkbox"/> Seasonal worker <input type="checkbox"/> Temporary employment <input type="checkbox"/> Stay at home parent <input type="checkbox"/> No answer/prefer not to say		Are you a single parent? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No answer/prefer not to say		Family member type: <input type="checkbox"/> Parent <input type="checkbox"/> Expecting mother <input type="checkbox"/> Foster parent <input type="checkbox"/> Grandparent or other relative		Do you have a high school diploma? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No answer/prefer not to say	
Adult's Ethnicity: (check only one)							
<input type="checkbox"/> Alaskan Native/American Indian <input type="checkbox"/> Pacific Islander		<input type="checkbox"/> Asian <input type="checkbox"/> White		<input type="checkbox"/> Black/African-American <input type="checkbox"/> Multiracial		<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Other _____	

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CHILD #1 only ages 0 to 5		For Office Use Only: GEMS ID #		Special Needs Determination <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
Child's First Name	Child's Last Name	Middle Initial	Child's Date of Birth ____/____/____ Month / day / year		Child's gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Child's Ethnicity: (check only one)					
<input type="checkbox"/> Alaskan Native/American Indian		<input type="checkbox"/> Asian		<input type="checkbox"/> Black/African-American	
<input type="checkbox"/> Pacific Islander		<input type="checkbox"/> White		<input type="checkbox"/> Hispanic/Latino	
		<input type="checkbox"/> Multiracial		<input type="checkbox"/> Other _____	
How many parents/guardians live in the home with this child?				<input type="checkbox"/> One <input type="checkbox"/> Two	
Does this child have any kind of health insurance now, such as through an HMO, private insurance, Medi-Cal, ACE for Kids or Healthy Families?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> No answer/prefer not to say	
Has a doctor or other health professional ever told you this child was developmentally delayed? A developmental delay means he/she is somewhat slower physically/mentally than other children the same age.				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> No answer/prefer not to say	
Has a doctor/other health professional ever told you this child has any of the other following disabilities or special needs					
(Check all that apply.)		<input type="checkbox"/> A speech impairment		<input type="checkbox"/> Another health impairment lasting 6 months or more	
<input type="checkbox"/> A serious emotional disturbance		<input type="checkbox"/> Deafness or another hearing impairment		<input type="checkbox"/> No	
<input type="checkbox"/> A specific learning disability		<input type="checkbox"/> Blindness or another visual impairment		<input type="checkbox"/> No answer/prefer not to say	
<input type="checkbox"/> Autism or pervasive developmental disorder		<input type="checkbox"/> An orthopedic impairment			
Does your child have any of the following? (Check all that apply) <input type="checkbox"/> IEP <input type="checkbox"/> IFSP <input type="checkbox"/> Mental health diagnosis					
Does this child have a regular doctor?				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No answer/prefer not to say	
Has this child ever had a well child visit with the doctor? (a doctor visit not related to illness or injury)		<input type="checkbox"/> Yes, when:	<input type="checkbox"/> less than 3 months ago <input type="checkbox"/> 3- 6 months ago <input type="checkbox"/> 6-12 months ago <input type="checkbox"/> more than 12 months ago		<input type="checkbox"/> No <input type="checkbox"/> Don't know No answer prefer not to say
Does this child have a regular dentist?				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No answer/prefer not to say	
Has this child ever had a dental exam?		<input type="checkbox"/> Yes, when:	<input type="checkbox"/> less than 3 months ago <input type="checkbox"/> 3- 6 months ago <input type="checkbox"/> 6-12 months ago <input type="checkbox"/> more than 12 months ago		<input type="checkbox"/> No <input type="checkbox"/> Don't know No answer prefer not to say
Has this child ever been given a Developmental Check-up/Screening?		<input type="checkbox"/> Yes, when:	<input type="checkbox"/> less than 3 months ago <input type="checkbox"/> 3- 6 months ago <input type="checkbox"/> 6-12 months ago <input type="checkbox"/> more than 12 months ago		<input type="checkbox"/> No <input type="checkbox"/> Don't know No answer prefer not to say
Is your child currently enrolled, or was your child previously enrolled, in a preschool?					
<input type="checkbox"/> Yes, my child is currently enrolled in a preschool program.					
<input type="checkbox"/> Yes, my child attended preschool in the past, but is not currently enrolled.					
<input type="checkbox"/> No, my child has never attended preschool.					
If you answered 'yes' to the question above, meaning your child has been enrolled in a preschool either now or in the past, please answer the following questions:					
If 'yes', what is the name of the program that your child is attending or did attend in the past? _____					
If your child has been enrolled in a preschool either now or in the past, for approximately how many months did your child attend?					
If your child has been enrolled in a preschool either now or in the past, how often each week does your child usually attend?					
<u>Circle One</u>					
Full days 1 2 3 4 5					
Half days 1 2 3 4 5					

CHILD #2 only ages 0 to 5		For Office Use Only: GEMS ID #		Special Needs Determination <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
Child's First Name	Child's Last Name	Middle Initial	Child's Date of Birth ____/____/____ Month / day / year		Child's gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Child's Ethnicity: (check only one)					
<input type="checkbox"/> Alaskan Native/American Indian		<input type="checkbox"/> Asian		<input type="checkbox"/> Black/African-American	
<input type="checkbox"/> Pacific Islander		<input type="checkbox"/> White		<input type="checkbox"/> Hispanic/Latino	
		<input type="checkbox"/> Multiracial		<input type="checkbox"/> Other _____	
How many parents/guardians live in the home with this child?				<input type="checkbox"/> One <input type="checkbox"/> Two	
Does this child have any kind of health insurance now, such as through an HMO, private insurance, Medi-Cal, ACE for Kids or Healthy Families?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> No answer/prefer not to say	
Has a doctor or other health professional ever told you this child was developmentally delayed? A developmental delay means he/she is somewhat slower physically/mentally than other children the same age.				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> No answer/prefer not to say	
Has a doctor/other health professional ever told you this child has any of the other following disabilities or special needs					
(Check all that apply.)		<input type="checkbox"/> A speech impairment		<input type="checkbox"/> Another health impairment lasting 6 months or more	
<input type="checkbox"/> A serious emotional disturbance		<input type="checkbox"/> Deafness or another hearing impairment		<input type="checkbox"/> No	
<input type="checkbox"/> A specific learning disability		<input type="checkbox"/> Blindness or another visual impairment		<input type="checkbox"/> No answer/prefer not to say	
<input type="checkbox"/> Autism or pervasive developmental disorder		<input type="checkbox"/> An orthopedic impairment			
Does this child have any of the following? (Check all that apply) <input type="checkbox"/> IEP <input type="checkbox"/> IFSP <input type="checkbox"/> Mental health diagnosis					
Does this child have a regular doctor?				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No answer/prefer not to say	
Has this child ever had a well child visit with the doctor? (a doctor visit not related to illness or injury)		<input type="checkbox"/> Yes, when:	<input type="checkbox"/> less than 3 months ago <input type="checkbox"/> 3- 6 months ago <input type="checkbox"/> 6-12 months ago <input type="checkbox"/> more than 12 months ago		<input type="checkbox"/> No <input type="checkbox"/> Don't know No answer prefer not to say
Does this child have a regular dentist?				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No answer/prefer not to say	
Has this child ever had a dental exam?		<input type="checkbox"/> Yes, when:	<input type="checkbox"/> less than 3 months ago <input type="checkbox"/> 3- 6 months ago <input type="checkbox"/> 6-12 months ago <input type="checkbox"/> more than 12 months ago		<input type="checkbox"/> No <input type="checkbox"/> Don't know No answer prefer not to say

Has this child ever been given a Developmental Check-up/Screening?	<input type="checkbox"/> Yes, when:	<input type="checkbox"/> less then 3 months ago <input type="checkbox"/> 3- 6 months ago <input type="checkbox"/> 6-12 months ago <input type="checkbox"/> more then 12 months ago	<input type="checkbox"/> No	<input type="checkbox"/> Don't know No answer prefer not to say
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Is your child currently enrolled, or was your child previously enrolled, in a preschool?

- Yes, my child is currently enrolled in a preschool program.
- Yes, my child attended preschool in the past, but is not currently enrolled.
- No, my child has never attended preschool.

If you answered 'yes' to the question above, meaning your child has been enrolled in a preschool either now or in the past, please answer the following questions:

If 'yes', what is the name of the program that your child is attending or did attend in the past? _____

If your child has been enrolled in a preschool either now or in the past, for approximately how many months did your child attend?

If your child has been enrolled in a preschool either now or in the past, how often each week does your child usually attend?

Circle One

Full days 1 2 3 4 5