



Enrollment Application

Office - 83 Pearl Street, Hyannis MA 02601
(508)775-6240 or (800)974-8860
FAX (508)775-3994

Parent/Guardian(s) Name's _____

Cell Phone _____ Home phone _____

Email (please print) _____

Street Address _____ Town/Zip _____

Mailing Address _____ Town/Zip _____

Household Type: 2 Parent Family Single Parent (mother figure) Single Parent (father figure)
Single Parent (living with partner) Foster family Grandparent Legal Guardian

Marital Status: Married Separated Single Divorced

Children in family:

Child Needs Care:

1. Name _____ M F D.O.B. _____ Yes No

Date Needed _____

Child care needs: Full Day (7:30-5:30 - Year Round) Part Day (4 hrs per day/5 days per week- School Calendar) 3-5 year olds only
After School/Vacation/Summers (Kindergarten – 5th grade, Year Round)

2. Name _____ M F D.O.B. _____ Yes No

Date Needed _____

Child care needs: Full Day (7:30-5:30 - Year Round) Part Day (4 hrs per day/5 days per week- School Calendar) 3-5 year olds only
After School/Vacation/Summers (Kindergarten – 5th grade, Year Round)

3. Name _____ M F D.O.B. _____ Yes
No

Date Needed _____

Child care needs: Full Day (7:30-5:30 - Year Round) Part Day (4 hrs per day/5 days per week- School Calendar) 3-5 year olds only
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Do you have a voucher from Child Care Network or Pace Child Care Works? Yes No

Are you currently homeless? Yes No

Are you under 20 years of age? Yes No Date of Birth: _____

Number of family members: _____ Yearly household income: _____

Is parent/guardian # 1 working? Yes Hours per week _____ No Seeking work

Is parent/guardian # 2 working? Yes Hours per week _____ No Seeking work

Other income (circle all that apply): Child Support SSI SSDI TAFDC Unemployment

Race/Ethnicity: American Indian Native Hawaiian Asian Bi-Racial/Multi-racial
White Black/African American Hispanic/Latino Other Refused

Language spoken at home _____

How did you hear about us? _____

Child's Doctor _____

Child's Dentist _____

Does your child/children have any allergies / nutritional concerns? _____

Please describe _____

Does your child/children have any medical / special needs? _____

Please describe _____

Is your child receiving Early Intervention Services or have an IEP or 504 from the Public School? Yes No

Se a sua primeira lingua for Português ou Espanol, e se preferir assistência no seu próprio idioma, por favor ligue para o nosso intérprete Fatima Mourao Messier eno telefone (508)775-6240 ramal 312.

Parent /Guardian Signature _____ **Date** _____

Over please.....