WAYNE STATE UNIVERSITY

For office use only:		
Program Year: 20___ - 20___	☐ **Tuition**	☐ **2 ½ yo**
Teacher: _____	☐ **GSRP**	☐ **3 yo**
Student UIC#: _____	☐ **CCAMPIS**	☐ **4 yo**
Date of Enrollment: _____		
Date Dropped: _____		

INITIAL APPLICATION & INTERVIEW FORM

☐ College of Education Early Childhood Center 4500 Cass Ave., Suite 1, Detroit, MI 48201 Phone: (313) 577-1686 Fax: (313) 577-6841	☐ Merrill Palmer Skillman Institute Early Childhood Center 87 East Ferry, Detroit, MI 48202 Phone: (313) 664-2533 Fax: (313) 664-2555

Date of Application:		
Child's Name:	**Birthdate:**	**Sex:** ☐ **F** ☐ **M**
Proof of Birth (Type of Document):	Birthplace (city, state or nation):	
If Applicable, Date of Arrival in the United States:		
Child's Address:	City & Zip:	
Home Telephone:	Alternate Telephone:	

Mother/Guardian's Name _____ Birthdate: _____

Place of Birth: _____

Home Address (if not the same as child's) _____

City/Zip _____

Phone Numbers: Home _____ Work _____ Cell _____

Email _____ WSU Email (if applicable) _____

Marital Status: ☐ Marries ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

(EF-7) Who has legal custody of the child?:

☐ Mother ☐ Father ☐ Foster Care ☐ Legal Guardian ☐ Grandparent

If guardian or foster parent (other than biological parent, please complete:

Legal Guardian's Name(s): _____ Case Number: _____

Please check one: ☐ Wayne State Undergraduate Student ☐ Wayne State Employee ☐ Not Applicable

If you are a WSU student, are you receiving a Pell Grant? ☐ Yes ☐ No

Father/Guardian's Name _____ Birthdate: _____

Place of Birth: _____

Home Address (if not the same as child's) _____

City/Zip _____

Phone Numbers: Home _____ Work _____ Cell _____

Email _____ WSU Email (if applicable) _____

Marital Status: ☐ Marries ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

EF-7 Who has legal custody of the child?:

☐ Mother ☐ Father ☐ Foster Care ☐ Legal Guardian ☐ Grandparent

If guardian or foster parent (other than biological parent, please complete:

Legal Guardian's Name(s): _____ Case Number: _____

Please check one: ☐ Wayne State Undergraduate Student ☐ Wayne State Employee ☐ Not Applicable

If you are a WSU student, are you receiving a Pell Grant? ☐ Yes ☐ No

EF-1 List ALL household members for which you are financially responsible (include self, other adults, and children

Name	Relationship to Child	Age	Sex

EF-4 Primary language spoken in the home: _____

Which of the following is the child's race (if multi-racial, place a check mark for each that applies):

☐ American Indian or Alaska Native ☐ Black or African-American ☐ White
☐ Asian American ☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic or Latino

Has your child attended school anywhere before? ☐ Yes ☐ No If yes, date they started school: _____

Name of School: _____ City, State: _____

EF-1 Family Income

Estimated annual income (last 12 months) before deductions, including overtime: $ _____*
* Please note: Should include income of all family members responsible for support of the child.

EF-1 Does your family receive benefits from Department of Health and Human Services (DHHS)? SSI? ☐ Y ☐ N

If yes, please explain: _____

EF-1 Mother/Guardian's Employment Status: ☐ Part Time ☐ Full Time ☐ Seasonal ☐ Unemployed

Job Description: _____

Employer: _____ Business Phone: _____

EF-5 Highest grade or degree completed: _____

Work/School Schedule (days & times): _____

_____

EF-1 Father/Guardian's Employment Status: ☐ Part Time ☐ Full Time ☐ Seasonal ☐ Unemployed

Job Description: _____

Employer: _____ Business Phone: _____

EF-5 Highest grade or degree completed: _____

Work/School Schedule (days & times): _____

_____

EF-2 & 3 Has your child been expelled from preschool or a child care center? ☐ Yes ☐ No

EF-6. Has someone in your home ever been a victim of abuse and/or neglect? ☐ Yes ☐ No

The above information is true and accurate to the best of my knowledge. I understand that if any of this information changes, or is found to be incorrect, I am obligated to immediately notify this program. I understand that the above information and all information contained in the child's folder will remain **CONFIDENTIAL.**

Parent/Guardian's Name (please print) _____

Parent/Guardian's Signature _____ **Date** _____

Additional Family Information:

Do you need to have written material translated into your native language? ☐ Yes ☐ No

EF-7 Mother's age at birth of first child _____

EF-2 & 7 Have you or any of your children been diagnosed with a disability or developmental delay? ☐ Yes ☐ No

If yes, explain _____

EF-7 Have you or any of your children had a long-term or chronic illness? ☐ Yes ☐ No

If yes, explain _____

EF-2, 3, & 7 Do you or any of your children receive special services? ☐ Yes ☐ No

If yes, explain _____

EF-2 Does the child you are enrolling in the program have special needs? ☐ Yes ☐ No Diagnosed? ☐ Yes ☐ No

EF-2 Does the child you are enrolling in the program have an IEP? ☐ Yes ☐ No

Date of IEP (if applicable): _____
Inclusive Classroom Specified? ☐ Yes ☐ No

EF-7 Has your child experienced parental or sibling loss due to death, divorce, military service, etc? ☐ Yes ☐ No

If yes, explain _____

EF-7 How long have you lived at your current address? _____

If your reply is less than a year, explain _____

Child's Medical History:

Birth weight _____ lbs. _____ oz. ☐ Full-Term ☐ Premature

Were there any complications during pregnancy or birth? ☐ Yes ☐ No

If yes, explain _____

EF 2 & 7 Does your child have any medical conditions? ☐ Yes ☐ No

If yes, explain _____

Does your child take any medications regularly? ☐ Yes ☐ No

If yes, explain _____

Does your child have any allergies? ☐ Yes ☐ No

If yes, explain _____

Does your child have any food restrictions? ☐ Yes ☐ No

If yes, explain _____

Medical Insurance	
Do you have medical insurance? ☐ Yes ☐ No	
Type of Medical Insurance:	Policy Number:
Type of MEDICAID Insurance (if applicable): Case #: Child's Recipient ID #:	

Background Information About Your Child:

What 10 words would you use to describe your child?

_____

_____

_____

What do you like most about your child?

_____

_____

_____

What do you find most challenging about caring for your child?

_____

_____

_____

What activity do you enjoy most with your child?

_____

_____

_____

What are three wishes you have for your child?

_____

_____

_____

My child is happiest when:

_____

_____

The kinds of play and activities my child enjoys most are:

_____

_____

I think this is because: _____

What upsets my child most is:

_____

_____

I think this is because: _____

To comfort my child, I:

_____

_____

_____

I think my child's greatest strengths are:

_____

_____

_____

I think my child needs help with:

_____

_____

_____

What are your goals for your child now? Over the next three months?

_____

_____

_____

What kinds of experiences can our program give your child to help him/her reach these goals?

_____

_____

_____

How can we work together with you to best support your child now? Over the next three months?

_____

_____

Parents of Children Enrolled in the COE Early Childhood Center and the Merrill Palmer Skillman Institute Early Childhood Center are Required to:

- Participate in parent meetings and family events.
- Furnish information regarding their child's developmental history, which will be held in strict confidence.
- Accompany their child into and out of the center to ensure their child's safety.
- Ensure that their child arrives and leaves at the specified times.
- Visit the center and volunteer in the classroom.
- Participate in two (2) home visits, as required by the Michigan Department of Education (if enrolled in the GSRP program).
- Participate in two (2) parent-teacher conferences, as required by the Michigan Department of Education, the College of Education Early Childhood Center, and Merrill-Palmer Skillman Institute Early Childhood Center.

I understand these expectations and agree to these program requirements. ☐ Yes ☐ No

I am interested in the following program for my child (please check those that apply):

☐ Tuition Program

- ☐ Full Day Program (M-F, 8:30-4:00)
- ☐ 3 Day Program (M, W, F, 8:30-4:00)
- ☐ 2 Day Program (T, Th, 8:30-4:00)
- ☐ Before-School Care (8:00 – 8:30) – Please note, there is an additional fee for this service.
- ☐ After-School Care (4:00 – 5:30) – Please note, there is an additional fee for this service.

☐ CCAMPIS Program (M-F, 8:30 – 4:00) – free for undergraduate students who are eligible under the grant guidelines.

- ☐ Before-School Care (8:00 – 8:30) – Please note, there is an additional fee for this service.
- ☐ After-School Care (4:00 – 5:30) – Please note, there is an additional fee for this service.

☐ GSRP Program (M-Th, 8:30 – 3:30) – free for families of 4 year olds that qualify under the grant eligibility criteria.

- ☐ Before-School Care (8:00 – 8:30) – Please note, there is an additional fee for this service.
- ☐ After-School Care (3:30 – 5:30) – Please note, there is an additional fee for this service.

Application was completed by:

Signature _____ Print Name _____

Date _____ Relationship to child _____

GSRP Documentation
Staff Complete This Section

The following documentation has been received:

☐ Birth Certificate	Date Received: _____
☐ Letter of Guardianship (if applicable)	Date Received: _____
☐ Income Verification	Date Received: _____
☐ Immunization Record	Date Received: _____
☐ Health Appraisal	Date Received: _____
☐ Head Start Referral (if applicable)	Date Received: _____
☐ ASQ	Date Received: _____

GSRP Eligibility
Staff Complete This Section

Eligibility Factors ***(check all that apply):***	***Type of Documentation*** ***(e.g., parent report, pay stub, IEP, etc.)***
☐ **EF-1.** **Quintile:** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** **% FPL:** _____ ☐ **GSRP Eligible** ☐ **Head Start Eligible**	
☐ **EF-2**	
☐ **EF-3**	
☐ **EF-4**	
☐ **EF-5**	
☐ **EF-6**	
☐ **EF-7**	

Staff Signature: _____ **Date:** _____

Director Signature Verifying & Auditing Form _____ **Date:** _____