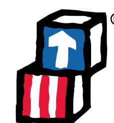
We are happy to help you with this application – just ask!

Lake Family Resource Center

890 Lakeport Blvd. Lakeport, Ca 95453
(707) 279-0563 FAX (707) 262-0344



Prenatal Application

Applicant's Name			**Applicant's Birth Date**	**Social Security #**
Spouse/Partner Name			**Spouse/Partner Birth Date**	**Social Security #**
Address			**City**	**Zip Code**
Mailing Address *(if different from above)*			**City**	**Zip code**
Phone Numbers:	**Home #** ( )	**Cell#** ( )	**Work#** ( )	**Message#** ( )

What is the best way to contact you: ☐ Home phone ☐ Cell phone ☐ E-mail ☐ Mail

Applicant's Race: ☐ Black ☐ White ☐ Biracial/Multi_______________
☐ Hispanic ☐ Native American ☐ Asian ☐ Other: ___________________
Spouse/Partner Race: ☐ Black ☐ White ☐ Biracial/Multi____________
☐ Hispanic ☐ Native American ☐ Asian ☐ Other: ___________________

Primary Language ☐ English ☐ Spanish
☐ Other:________________
Level of English skills-(circle one) Proficient Moderate Poor None

How did you hear about our program? ☐ Radio ☐ Newspaper ☐ Friend ☐ HS/EHS brochure ☐ Walk-in
☐ LFRC Booth ☐ EHS Employee ☐ Current/Previous HS/EHS parent ☐ LFRC Website ☐ LFRC Face book
☐ Other Agency; Name: __________________________ ☐ Other: __________________________

Please attach proof of your family's income. ☐ Copy attached

Do you currently receive? ☐ Cash-aid ***- If yes please attach proof.*** ☐ SSI ***- If yes please attach proof.***
☐ Food Stamps ☐ WIC

Application Employment information

Employer/Occupation	**Education level**	**Income Source**
Applicant:	(Circle one) G9 G10 G11 G12 HSG AS BS GED COL (some college) Master's CTG (college degree)	☐Full Time ☐Part Time ☐ Unemployed ☐ Retired/Disabled ☐ Seasonally (how many months)______ ☐**Training/School** ☐**Other________**
Spouse/Partner	(Circle one) G9 G10 G11 G12 HSG AS BS GED COL (some college) Master's CTG (college degree)	☐Full Time ☐Part Time ☐ Unemployed ☐ Retired/Disabled ☐ Seasonally (how many months)______ ☐**Training/School** ☐**Other________**

List other children living in the home that are related to you by blood, marriage or adoption:

Child's Name	**Date of Birth**	**Sex**		**Relation to *Applicant***
1.		☐ Male	☐ Female	
2.		☐ Male	☐ Female	
3.		☐ Male	☐ Female	
4.		☐ Male	☐ Female	
5.		☐ Male	☐ Female	

Are any of the above children currently enrolled in Head Start or Early Head Start? ☐ YES ☐ NO

Put a check mark (✓) in the box of any and all situations that currently apply to your family:
Eligibility priority may be determined by the following:

☐ Been exposed to domestic Violence

☐ Sibling attends/attended EHS

☐ Self and/or spouse/partner has history of or is incarcerated.

☐ History of drug or alcohol abuse.

☐ Self and/or spouse/partner is in a recovery program for substance abuse

☐ Self and/or spouse/partner disabled
If yes explain:
____

☐ Self and/or spouse/partner has mental illness
If yes explain:
____

☐ Currently Attending ESL, Literacy Program, School or job training

☐ Currently homeless or in transitional housing.

☐ Self or other household member on active military duty.

☐ Formal written referral from another agency attached:
Name:_________________________________

☐ Teen parent

We need verification of pregnancy. (Pregnancy verification from physician, clinic or WIC.)

Copy Attached ☐

Expected delivery date _____ / _____ /_____
Mo Day Year

Is this pregnancy considered high risk? Yes/No

Is a doctor following your current pregnancy? ↑Yes ↑No

If yes, doctors name:________________________

When did you first receive prenatal care? ____________________

When was your last prenatal care visit? _____________________

Is this your first pregnancy? ↑Yes ↑No If no, how many others? _____

Has the mother ever had: ↑Premature Labor ↑C- Section ↑Asthma ↑ Heart problems

Is there a family history of any of the following?

Bleeding Disorders ↑Diabetes Seizures

High Blood Pressure ↑ ↑Sickle Cell Anemia

What is your primary medical insurance? ___________________

Provide Card # _____________________

When was your last dental exam? __________________________

We do not discriminate on the basis of gender, sexual orientation, ethnic group identification, race, ancestry, national origin, religion, color, mental or physical disability, or immigration status in determining which families are served.

I certify this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during business hours. This information will not be released without my written consent.

Applicant Signature: ____ Date: ___________________________