Workforce Solutions MRG
Child Care Services
Pre Application

Pre-Assessment for Child Care Services **1**

#CCPSF001

Email: **or Fax:**

Direct line: 830-278-4491
Phone #1-800-888-9436 / 211

Case Information *(Mother or Father)*

Name: *Last, First, M*	Date of Birth:	Social Security Number (voluntary/optional)	Sex:	Ethnicity: Race:
Address: Mailing Address *(if different)*:	Apt #:	City/State:	Zip Code: County:	
Home Phone:	Work Phone:	Cell Phone:	Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Place of Employment: Address:		Work schedule (ex. M-F 8am-5pm) Number of hours you work weekly:	Hire Date:	
Hourly Pay Rate: $________	Pay Frequency: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Bi-Monthly	Other Income: ☐ Tips $____ ☐ Commission $____/mo ☐ Workman's Comp $____	☐ Bonuses $____ ☐ Unemployment $____ ☐ SSDI $____	
Name of School or Training Institution: Area of Concentration / Major:		School Schedule (ex. M-F 8am-5pm)	Hours this semester:	School start date:

Children Needing Care

1. Name:	Date of Birth:	Social Security Number (voluntary/optional) US Citizenship: ☐ Yes ☐ No	Sex:	Ethnicity: Race:
Does the child have a disability? ☐ Yes ☐ No If yes, list disability:	Does child attend school? ☐ No ☐ Yes Name of School & Grade:		Relationship to you:	
2. Name:	Date of Birth:	Social Security Number (voluntary/optional) US Citizenship: ☐ Yes ☐ No	Sex:	Ethnicity: Race:
Does the child have a disability? ☐ Yes ☐ No If yes, list disability:	Does child attend school? ☐ No ☐ Yes Name of School & Grade:		Relationship to you:	
3. Name:	Date of Birth:	Social Security Number (voluntary/optional) US Citizenship: ☐ Yes ☐ No	Sex:	Ethnicity: Race:
Does the child have a disability? ☐ Yes ☐ No If yes, list disability:	Does child attend school? ☐ No ☐ Yes Name of School & Grade:		Relationship to you:	
4. Name:	Date of Birth:	Social Security Number (voluntary/optional) US Citizenship: ☐ Yes ☐ No	Sex:	Ethnicity: Race:
Does the child have a disability? ☐ Yes ☐ No If yes, list disability:	Does child attend school? ☐ No ☐ Yes Name of School & Grade:		Relationship to you:	
5. Name:	Date of Birth:	Social Security Number (voluntary/optional) US Citizenship: ☐ Yes ☐ No	Sex:	Ethnicity: Race:
Does the child have a disability? ☐ Yes ☐ No If yes, list disability:	Does child attend school? ☐ No ☐ Yes Name of School & Grade:		Relationship to you:	

2nd Parent's Employment or Your SECOND Employment: Address:	Work Schedule (ex. M-F 8am-5pm) Number of hours you work weekly:	Work Phone:	Work start date:

Hourly Pay Rate $________	Pay Frequency: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Bi-Monthly	Other Income: ☐ Tips $ ____________ ☐ Bonuses $ ____________ ☐ Commission $ ____________/mo ☐ Unemployment $ ____________ ☐ Workman's Comp $____________

Name of School or Training Institution: Area of Concentration / Major:	School Schedule (ex. M-F 8am-5pm)	Hours this semester:	School start date:

Family Members (not previously listed)
Total number of people in your household including self and spouse or significant other:

1. Name:	Date of Birth:	SSN **(voluntary/optional):**	Relationship to you:
2. Name:	Date of Birth:	SSN **(voluntary/optional):**	Relationship to you:
3. Name:	Date of Birth:	SSN **(voluntary/optional):**	Relationship to you:

This Box must be checked off

Does your total family assets exceed $1 million dollars? ☐ YES ☐ NO

Do You Receive Any of the Following?
Public Assistance T.A.N.F,SNAP) ☐ Yes ☐ No
☐ TANF
☐ SNAP
☐ Other____________________

I understand that by signing this form, I am applying for services from the Texas Workforce Commission or from an agency under contract with the commission. All information provided represents a complete and accurate statement of my family's (clients) circumstance at the time of application.

Head of Household Signature: X______________________________ **Date: X**______________

Equal opportunity employer/program
Auxiliary aids and services available upon request to individuals with disabilities
Relay Texas: 1-800-735-2989 (TDD) or 7-1-1 (Voice)