

**DEPARTMENT OF DEFENSE CHILD DEVELOPMENT PROGRAM
REQUEST FOR CARE RECORD**

(Read Privacy Act Statement and Instructions on back before completing form.)

OMB No. 0704-0515
OMB approval expires
May 31, 2017

The public reporting burden for this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Information Management Division, 4800 Mark Center Drive, Alexandria, VA 22350-3100 (0704-0515). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

**PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO:
OFFICE OF FAMILY POLICY/CHILDREN AND YOUTH, 4800 MARK CENTER DRIVE, SUITE 03G15, ALEXANDRIA, VA 22350-1400**

1. DATE OF REQUEST (YYYYMMDD)	2. EXPIRATION DATE (YYYYMMDD) (To be completed by Facility)
-------------------------------	---

3. FAMILY INFORMATION

a. SPONSOR'S NAME (Last, First, Middle Initial)		b. SPOUSE'S NAME (Last, First, Middle Initial)	
c. CHILD'S NAME (Last, First, Middle Initial)		d. CHILD'S DATE OF BIRTH (YYYYMMDD)	e. CHILD'S AGE
f. HOME ADDRESS (Street, City, State, Zip Code)		g. SPONSOR'S BRANCH OF SERVICE	
		h. DUTY ORGANIZATION	
i. HOME TELEPHONE NUMBER (Include Area Code)		j. DUTY TELEPHONE NUMBER (Include Area Code)	

k. SIBLING CARE

(1) NAME (Last, First, Middle Initial)	(2) DATE OF BIRTH (YYYYMMDD)	(1) NAME (Last, First, Middle Initial)	(2) DATE OF BIRTH (YYYYMMDD)

4. PROGRAM(S) DESIRED (X as applicable)

a. FULL-DAY CARE	d. FAMILY DAY CARE (FDC)
b. PART-DAY CARE	e. PART-DAY ENRICHMENT
c. SCHOOL-AGE	f. PRE-SCHOOL

5. AGE GROUP (X one)

a. INFANTS (0 - 12 months)
b. TODDLERS (13 - 35 months)
c. PRESCHOOL (3 - 5 years)
d. SCHOOL AGE (5+ years)

6. SPONSOR STATUS (X one)

a. SINGLE MILITARY	e. SINGLE DOD CIVILIAN	i. MILITARY/UNEMPLOYED SPOUSE
b. DUAL MILITARY	f. RETIRED MILITARY	j. MILITARY/OTHER THAN DOD SPOUSE
c. MILITARY/DOD SPOUSE	g. MILITARY RESERVE	k. OTHER (Specify)
d. DUAL DOD CIVILIANS	h. NATIONAL GUARD	

7. PRESENT CHILD CARE ARRANGEMENTS (X as applicable)

a. FCC ON-INSTALLATION	d. CIVILIAN CDC	g. IN-HOME CARE
b. FCC OFF-INSTALLATION	e. MILITARY ALTERNATE CARE	h. NO PRESENT CARE
c. OTHER MILITARY CHILD DEVELOPMENT CENTER (CDC)	f. NON-MILITARY ALTERNATE CARE	i. OTHER (Specify)

8. GENERAL INFORMATION (X and complete as applicable)

YES	NO	a. IF CHILD IS NOT PRESENTLY IN CARE, IS EMPLOYMENT OF SPOUSE IMPACTED? (If Yes, estimate average annual income lost)	YES	NO	c. IS CHILD ON OTHER MILITARY WAITING LIST? (If Yes, name installation)
b. HAS CHILD BEEN IDENTIFIED FOR SPECIAL NEEDS CARE?			d. CURRENT COST OF CARE PER WEEK (If child is currently in care)		

9. ACCOMMODATION UPDATES/REVERIFICATION (For Office Use Only)

	(1)	(2)	(3)	(4)	(5)
a. DATE CALLED (YYYYMMDD)					
b. DECLINED/ PLACED					
c. COMMENTS/ INITIALS					
d. PLACEMENT TIME (In months)					

Child Development Center Waitlist Parent Survey

Applicants Name: _____

Date: _____

Email Address: _____

Phone #: _____

Child's Name _____

Child's DOB: _____

Please circle yes or no to the following questions:

- | | | |
|--|------------------------------|-----------------------------|
| 1. Are you familiar with the Family Child Care program at Hill AFB? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Have you ever used the services of the Family Child Care program? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, were you satisfied with the quality of care? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Are you interested in using Family Child Care? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If no, what is the reason (please circle all that apply) | | |

- | | | |
|---|--|---|
| <input type="checkbox"/> Cost of Care | <input type="checkbox"/> Training of Provider | <input type="checkbox"/> Lack of Materials |
| <input type="checkbox"/> Location of Homes | <input type="checkbox"/> Hours of Operation | <input type="checkbox"/> Reliability of Providers |
| <input type="checkbox"/> Lack of Curriculum | <input type="checkbox"/> Lack of socialization opportunities | |
| <input type="checkbox"/> Lack of structured routine | <input type="checkbox"/> Lack of field trip opportunities | |

Would you be willing to be contacted concerning your responses above? Yes No

4. Are you interested in receiving more information concerning current openings and programs that Family Child Care has to offer? Yes No

Thank you for taking the time to fill out this survey. If you have any questions or concerns please feel free to stop by the Family Child Care office at building 460 or call 777-0695.