Strengthening Working Families Initiative (SWFI)

Referral Date: _____

Referral Source: _____

Name:_____ DOB_____

Address:_____

Phone:
_____AlternateNumber:_____

Speak English: ☐ Yes ☐ No
Specify Language if other than English: _____

Currently Enrolled in a training/ certification program in the following industries: Health Care, Advanced Manufacturing, and Information Technology:
☐ Yes (specify below) ☐ No

Name, Address, Telephone Number:	**Certification/ Training Program:**
Person of Contact:	**Start Date:** **Expected completion date:**

Number of Children in Household: _____

Name	Date of Birth	Age	Disabled Y/N	M/F

Are any children in the household currently enrolled in school and/or a child care program: YES ☐ (Specify Below) NO ☐

☐ State Certified Day Care ☐ Before/After School Care ☐ Head Start

☐ Other:_____

Name of Child Enrolled	Name, Address of child Care Facility/ Program

Are you currently in need of child care: ☐ YES ☐ NO

If yes, what hours of child care are needed?

Name , Age	Days, Hours of Assistance Needed	Start Date