

INTAKE FORM - PROVIDER (CORE PARTICIPANT) INFORMATION

Agency Name:		Program Name:	
GEMS Defined Provider ID:		Alternate Provider ID:	
Provider Agency Name (if applicable):			
Provider's Street Address:		City:	
Zip:	State:	Phone Number:	
Provider's First Name:		Provider's Last Name:	Middle Initial
Provider's Mother's First Name:		Provider's Mother's Maiden Last Name:	
Program Intake Date: (mm/dd/yyyy) ____ / ____ / ____		Provider's date of birth: (mm/dd/yyyy) ____ / ____ / ____	
Is this a First 5 Participant? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider's gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Consent form signed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date consent form signed: ____ / ____ / ____ (mm/dd/yyyy)	
Provider type: <input type="checkbox"/> Center-based child care/ECE provider <input type="checkbox"/> Family child care/ECE provider <input type="checkbox"/> Licensed <input type="checkbox"/> Not licensed <input type="checkbox"/> Kindergarten teacher <input type="checkbox"/> Mental health provider <input type="checkbox"/> Pediatric health care provider <input type="checkbox"/> Oral health care provider <input type="checkbox"/> Prenatal care provider <input type="checkbox"/> Parent educator <input type="checkbox"/> Home visitor <input type="checkbox"/> Lactation educator/consultant <input type="checkbox"/> Other child development provider <input type="checkbox"/> Other family support provider <input type="checkbox"/> Other health care provider		What is the highest level of education you've completed? <input type="checkbox"/> Less than high school <input type="checkbox"/> High school graduate/GED <input type="checkbox"/> Some college <input type="checkbox"/> 2-year college graduate/AA <input type="checkbox"/> 4-year college graduate/BA <input type="checkbox"/> Graduate degree <input type="checkbox"/> No answer/prefer not to say	
Participant ethnicity (check all that apply)			
<input type="checkbox"/> Alaska Native/American Indian <input type="checkbox"/> Asian (check below) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian	<input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino (check below) <input type="checkbox"/> Mexican, Mexican-American, Chicano <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Central American <input type="checkbox"/> Other Hispanic/Latino	<input type="checkbox"/> White <input type="checkbox"/> Pacific Islander (check below) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Unknown <input type="checkbox"/> Other
What language do you speak?			
<input type="checkbox"/> Mostly or all English <input type="checkbox"/> English and another language equally (indicate below)		<input type="checkbox"/> Mostly another language (indicate below) <input type="checkbox"/> Unknown	
<input type="checkbox"/> Cantonese <input type="checkbox"/> Hindi <input type="checkbox"/> Japanese <input type="checkbox"/> Korean	<input type="checkbox"/> Khmer (Cambodian) <input type="checkbox"/> Lao <input type="checkbox"/> Mandarin (Putonghua) <input type="checkbox"/> Mixteco	<input type="checkbox"/> Punjabi <input type="checkbox"/> Spanish <input type="checkbox"/> Tagalog (Filipino) <input type="checkbox"/> Vietnamese	<input type="checkbox"/> Some other language <input type="checkbox"/> Unknown