SAFE CRIBS

PLATTE COUNTY

Crib Program Application

Applicant Information

Mother's Name:_____
First *Middle* *Last*

Date of Birth:_____ Social Security #:_____

Address:_____
Street *City* *State* *Zip Code*

Phone:_____ Message Phone:_____

OB Doctor/Clinic:_____

Baby's Due Date:_____

Baby's Name (if born):_____

Baby's DOB (if born ****must be less than 90 days old**)_____

Income/Insurance Information

Gross Annual Household Income (before taxes): _____

Medicaid Benefits: **Y** **N**

Medicaid Plan Name/Number:_____

Does family receive public assistance? (circle all that apply) SSI Food Stamps WIC TANF

Household Information

Number of persons in household: Adults:_____ Children:_____

List the names and ages of other children in the household:

Name:_____ Age:_____

Name:_____ Age:_____

Name:_____ Age:_____

Name:_____ Age:_____

What attempts were made to obtain a safe crib?_____

Is this crib a replacement for an old or used crib? **Y** **N**

I authorize the referring agency to share this information with PCHD/Safe Crib Program, who will forward this information to the appropriate agencies in order to complete the crib assessment for the crib application. <u>I understand this application does not guarantee a crib.</u>

Signature:_____ **Date:**_____

Signature of rep from agency assisting in referral:_____ **Date:**_____

Agency:_____