

Killingly Public Schools
Family Resource Center
How Can We Help You?

What is your marital status? Single Married Separated Living Together Widowed Divorced

How many people live in your household? Adults: ____ Children: ____ Are you currently expecting? Yes No

Do you: Own Rent Reside with family or friends Other: _____

Do you have access to reliable transportation? Yes No
If no, are you able to get yourself and your children back and forth to appointments, etc?
 Yes No Sometimes
Will your child need transportation to get to /from school? Yes No

Would a member of your household be interested in information regarding:
 Employment Adult Education G.E.D.

What services does your family currently use?

<input type="checkbox"/> Food Pantry	<input type="checkbox"/> TANF	<input type="checkbox"/> WIC	<input type="checkbox"/> Husky Health
<input type="checkbox"/> Heating Assistance	<input type="checkbox"/> Diaper Bank	<input type="checkbox"/> SNAP	<input type="checkbox"/> DCF Support
<input type="checkbox"/> Clothing Assistance	<input type="checkbox"/> Counseling Services	<input type="checkbox"/> Access Agency	<input type="checkbox"/> Supportive Housing
<input type="checkbox"/> Pediatric Dental Screenings/Care		<input type="checkbox"/> Playgroups	

Would you be interested in?

<input type="checkbox"/> Food Pantry	<input type="checkbox"/> TANF	<input type="checkbox"/> WIC	<input type="checkbox"/> Husky Health
<input type="checkbox"/> Heating Assistance	<input type="checkbox"/> Diaper Bank	<input type="checkbox"/> SNAP	<input type="checkbox"/> Childcare
<input type="checkbox"/> Clothing Assistance	<input type="checkbox"/> Counseling Services	<input type="checkbox"/> Access Agency	<input type="checkbox"/> Supportive Housing
<input type="checkbox"/> Pediatric Dental Screenings/Care		<input type="checkbox"/> Playgroups	<input type="checkbox"/> Holiday Support
<input type="checkbox"/> Other: _____			

In which areas do children and families in your community face the greatest challenges? _____

What prevents you and your family from accessing available services you may need? _____

Please see other side

Do you have concerns regarding your child in any of the following areas?

- | | | |
|--|--|--|
| <input type="checkbox"/> Medical | <input type="checkbox"/> Developmental | <input type="checkbox"/> Social-Emotional-Behavioral |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Academic | <input type="checkbox"/> Motor |
| <input type="checkbox"/> Speech/Language | <input type="checkbox"/> Other: _____ | |

Is there anything else you would like to tell us about your child or family? _____

In additional to English, are there any other languages spoken in your home? Yes No

If yes, what language? _____

Would you be interested in information about becoming a foster or adoptive parent? Yes No

Were you referred by a community agency? No Yes, Agency Name: _____

Parent/Guardian Name: _____ Date: _____
(Please print)

Best way to reach me: _____

Please indicate which school(s) your children attend.

- GECC KCS KMS KIS KHS n/a

Required for Preschool Registration ONLY

How many adults in your household are currently employed? _____

What is the current annual household income? _____

Do you receive SSI? Yes No Do you receive child support? Yes No

Thank you.

For more information, see the contact information below.

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