



CONTROL NUMBER:

LIVESCAN INFORMATION FORM

PERSONAL INFORMATION					
LAST	Name				
FIRST	Name			Middle Name:	
Other names you have been known by:					
Home Address	<i>(physical address)</i>				Apt./Unit #
City		State	Zip	Phone	
IDENTIFYING INFORMATION					
(Current) Hair Color:	Eye Color:	Height	weight	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> unknown	
Social Security No.	Place of Birth: (If US – city, state or Territory)			Date of Birth:	
Race: <input type="checkbox"/> Caucasian/Mexican <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> unknown				Country of Citizenship:	
BUSINESS INFORMATION					
Name of employing child Care facility or other agency:					
Address of Employing agency:					
City	State	Zip		Phone:	
Please check facility type and your position:				Method of Payment	
Child Care Center:	<input type="checkbox"/>	Owner/Operator/Director	<input type="checkbox"/>	Personal Check: <input type="checkbox"/>	
Religious Exempt Child Care Facility:	<input type="checkbox"/>	employee	<input type="checkbox"/>	Check from facility: <input type="checkbox"/>	
Non-Public School:	<input type="checkbox"/>	substitute	<input type="checkbox"/>	Personal Credit Card: <input type="checkbox"/>	
Licensed Family Child Care Home:	<input type="checkbox"/>	volunteer	<input type="checkbox"/>	Facility Credit Card: <input type="checkbox"/>	
Registered Family Child Care Home:	<input type="checkbox"/>	Family or household member	<input type="checkbox"/>	Money Order/Cashier's Check: <input type="checkbox"/>	
Other:	<input type="checkbox"/>	Other:	<input type="checkbox"/>	Cash: <input type="checkbox"/>	Retake: N/C <input type="checkbox"/>
I affirm that the information I have provided above is correct, accurate and truthful to the best of my knowledge. I also understand that if I pay by a check with insufficient funds, I will be responsible for the original charge and additional fees required by the bank and Coalition.					
Applicant Signature:			Date:		
FOR COALITION USE ONLY (DO NOT WRITE BELOW)					
Form(s) of verifying identification:				Number (if applicable)	
Comments					
Livescan Number if known:					
Program:	CHILD CARE:	VECHS			
FP Processed by:					
DATE Completed:					