Southern Tier Health Care System Inc.

Cribs for Kids®
Helping every baby sleep safer

Request Crib Application

This program is for low-income individuals who do not have the ability to create any other safe sleep arrangements for their baby and is brought to you by Cribs for Kids®

Applicant's Information

Full Name: _____
Last *First*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: ( ) (H / C / W) Email Address: _____

Relation to Baby: _____ Applicant's Occupation: _____

Applicant's Demographic Information

Racial or Ethnic Group

- ☐ American Indian/Alaskan Native
- ☐ Asian/Pacific Islander
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ White/Caucasian
- ☐ Other Please Specify: _____

Age:

- ☐ 18 Years or Younger
- ☐ 19-25 Years
- ☐ 26-30 Years
- ☐ 31-35 Years
- ☐ 36-40 Years
- ☐ 40 Years or Older

Education Level:

- ☐ Some high school
- ☐ High school graduate
- ☐ G.E.D. certificate
- ☐ Some college
- ☐ College graduate
- ☐ Other Please Specify: _____

Living Situation:

- ☐ Rent
- ☐ Own
- ☐ Other Please Specify: _____

What circumstance(s) have lead you to be in need of a crib?

_____

Household Size:

_____

Income Level:

- ☐ $0 - $10,000
- ☐ $10,000 - $20,000
- ☐ $20,000 - $30,000
- ☐ $30,000 - $40,000
- ☐ $40,000 - $50,000
- ☐ $50,000 & Over

Please see back side

Baby's Information

Full Name: _____
Last *First*

Date of Birth/
Due Date: _____
Month *Day* *Year*

Baby's Demographic Information

Racial or Ethnic Group

- ☐ American Indian/Alaskan Native
- ☐ Asian/Pacific Islander
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ White/Caucasian
- ☐ Other Please Specify: _____

Age

- ☐ Prenatal
- ☐ 0-2 Months
- ☐ 2-4 Months
- ☐ 4-6 Months
- ☐ 6-12 Months
- ☐ 1 Year or Older

Was the baby born early?

- ☐ Yes
- ☐ No

If yes, how many weeks early? _____

Sex of the baby?

- ☐ Female
- ☐ Male
- ☐ Unknown

Is the baby breast or bottle fed?

- ☐ Breast fed
- ☐ Bottle fed
- ☐ Both

Current sleeping location of baby?

- ☐ Bed
- ☐ Car Seat
- ☐ Other, Please Specify: _____

Current sleeping position of baby?

- ☐ Belly
- ☐ Back
- ☐ Side

How did you hear about our program? _____

Please send the completed form to Southern Tier Health Care System Inc. using any one of the three following methods:

E-mail: jciminesi@sthcs.org

Fax: (716)-372-5217

Mail: Southern Tier Health
Care System Inc.
1 Blue Bird Sq.
Olean, NY 14760

For Official Use Only:

Facility location: _____ Personnel name: _____ Date: _____

☐ Approved

☐ Denied