Children's Services
Welcome to Head Start & Early Head Start!
Program Year_____

Thank you for taking the time to complete the attached application. You may submit your application to the Early Head Start or the Head Start Program.

To complete the application for Head Start or Early Head Start, we will need the following:

1. Proof of all income from the previous year or 12 months from the date you turn in your application.

   Examples:
   ____Most recent income Tax Form 1040A or 1040 and W-2 forms

   ____Pay stubs for all jobs

   ____Computer printout of TANF benefits or SSI

   ____Proof of Child Support Benefits letter or print out documentation

2. _____Child's original Birth Certificate or Baptismal Record

For your child to be enrolled we will need:

1. ____Child Immunization Record

2. ____Class schedule showing parent's school status (if applicable) or job training for Full Day/Full Year applicants.

3. ____Child's Certificate of Indian Blood (CIB) if applicable.

4. ____Current Medicaid Card/Insurance Card

5. ____If your child has a diagnosed disability, please submit copies of your child's most recent IEP IFSP records from the Special Education Program providing services (we can assist you in obtaining these records with your written authorization.)

6. ____For children who are in Protective Custody or who are living with Foster Parents, please submit court documentation of this placement.

PRESBYTERIAN MEDICALSERVICES
CHILDREN'SSERVICES
A-1a

For Office Use Only Session Requested_____

□ Application Completed (initial)_____Selected □ YES □ NO Date Selected_____#Household_____

□ Criteria Weight_____□ Over Income by $ □ Income Eligible □ Child Age _____

□ If over income approved, give reason_____

_____

_____ _____ _____
Authorized Personnel **Authorized Personnel** **Authorized Personnel**

COUNTY:_____SCHOOLDISTRICT:_____

SITE:_____ PROGRAM:_____

APPLICATION DATE:_____

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SECTION 1: APPLICANT INFORMATION

Male □
Female □

How did you hear about Head Start/Early Head Start?_____

CHILD'S NAME:_____DATE OF BIRTH:_____

Parent/Guardian's Name:_____

Mailing Address:_____
Street or PO Box City State Zip

Living Address:_____
Street or County Rd. Home Phone #

_____
Daytime Phone #

Child's Race:

□ Bi-racial
□ White
□ American Indian_____
African American/Black

□ Japanese

□
□ Asian
□ Pacific Islander
□ Chinese □ Other
□ Korean
□ Vietnamese
□ Hawaiian
□ Filipino

Language:
What language is spoken the most in your home?_____
Does your child speak English? □ Very Well □ Well □ Not Well □ Not at all
Does your child speak any other language?_____

SECTION 2: DISABILITIES INFORMATION

Has your child been diagnosed with or suspected of having a disability of developmental delay?
□ YES □ NO
If yes please list:_____
_____
_____
_____

At risk for developmental delay due to biological, medical, or environmental factors?
□ YES □ NO

Complications at Birth:
□ Low birth weight
□ Premature
□ Prenatal exposure to drugs, medications, etc. known to be associated with developmental delay.

Date of Evaluation: _____
Who Completed Evaluation: _____
Does your child require any medical accommodations? ____Yes____No
Does your child take any medications? ____Yes____No
If YES please specify: _____
Is your child on a special diet or have allergies to any foods? ____Yes____No
If YES please specify: _____

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SECTION 3: FAMILY INFORMATION

Indicate Family Type:

□ Two parent family (married or common law)
□ Single Parent Family: Child lives with_____Mother____Father
□ Other Relative (s): Specify: _____
□ Foster Family
□ Other Family Type: _____
□ Living Together

Please list below everyone living in your household beginning with the Head of Household:

	Name	DOB	Relationship to Child	Ethnicity Language	Employed PT/FT	PT/FT Grade EHS
1						
2						
3						
4						
5						
6						
7						
8						

Number of Adults: _____ **Number of Children:** _____

Rev. 3/27/2018SECTION 4: EDUCATION/EMPLOYMENT INFORMATION

Mother/Guardian's Name:	Father/Guardian's Name:
Race: □ Bi-Racial _____ □ White □ Black □ American Indian □ □ Spanish Origin (Specify) _____ □ □ Pacific Islander _____ □ Chinese □ Vietnamese □ Korean □ Japanese □ Hawaiian □ Filipino □ Samoan □ □ Asian Indian □ Other	Race: □ Bi-Racial _____ □ White □ Black □ American Indian □ Spanish Origin (Specify) _____ □ □ Pacific Islander __ □ Chinese □ Vietnamese □ Korean □ Japanese □ Hawaiian □ Filipino □ Samoan □ Guamanian □ Asian Indian □ Other
Language: What language is spoken? _____ Do you speak any other language(s)? _____	Language: What language is spoken? _____ Do you speak any other language(s)? _____
Employment: □ Employed Hours per Week _____ □ Full Time (28+ hours) □ Part Time □ Seasonal □Temp. **Employer:** Name:_____ Address:_____ City:_____ Phone: _____	Employment: □ Employed Hours per Week _____ □ Full Time (28+ hours) □ Part Time □ Seasonal □Temp. **Employer:** Name:_____ Address:_____ City:_____ Phone: _____
Education **Highest Grade Completed:** □ No school completed □ High School Graduate □ GED □ Less than or equal to 4th Grade □ 5th – 8th Grade □ 9th Grade □ 10th Grade 11th Grade □ 12th Grade (no diploma) □ Some College (no degree) □ Associate's Degree □ Bachelor's Degree □ Graduate Degree □Other **Current Education:** □ Student □ Year Round □ Full Time (12+ hours) □ Part Time (less than 12 credit hours) Field of Study: _____ School: _____	Education **Highest Grade Completed:** □ No school completed □ High School Graduate □ GED □ Less than or equal to 4th Grade □ 5th – 8th Grade □ 9th Grade □ 10th Grade 11th Grade □ 12th Grade (no diploma) □ Some College (no degree) □ Associate's Degree □ Bachelor's Degree □ Graduate Degree □Other **Current Education:** □ Student □ Year Round □ Full Time (12+ hours) □ Part Time (less than 12 credit hours) Field of Study: _____ School: _____

SECTION 5: CHILD CARE INFORMATION

Who cares for your child when you are at work or school:

□ Child care center, please specify: _____
□ Child care home please specify: _____
□ Relative or other adult in **your** home
□ Relative or other adult in **their** home.
□ Other: _____

How is the child care paid for:

□ Self Pay □ Full Price □ Sliding Scale □ Co-Pay
□ Assistance (specifysource) _____

Do you need child care year round? □YES, why? _____
□ NO, why? _____

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SECTION 6: HOUSING INFORMATION

Type of Housing: Do you:
□ Mobile Home □ House □ Apartment □ Other □ Rent □ Own □ Other

Length of time at current address: _____
Number of times family has moved in the past 12 months: _____
Have you been homeless in the past 12 months: □YES □ NO

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SECTION 7: TRANSPORTATION INFORMATION

Do you have access to a vehicle: □YES □NO

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SECTION 8: PROGRAM INFORMATION

Early Head Start (0 to 35 mo.) □
Head Start (3 to 5 years) □ Site Preference: _____

My preference is: (check all that apply)

	PROGRAM SERVICES	EXPLAIN WHY
	Full Day Year Round (times vary)	
	Full Day/School Year (times vary)	
	Part Day (4-6 hrs. per day) School Year	
	Morning Session (3 ½ hrs.) School Year	
	Afternoon Session (3 ½ hrs/) School Year	
	Home Based Services	

SECTION 9: FAMILY ASSISTANCE INFORMATION

What other income or assistance is your family currently receiving or need?

Receiving?	Receiving?	Need?	Need?
□ TANF/CASH Grant	□ Food Stamps	□ TANF/CASH Grant	□ Food Stamps
□ Unemployment Insurance	□ WIC/ECHO	□ Unemployment Insurance	□ WIC/ECHO
□ SSDI – Disabilities/Survivor's	□ Medicaid	□ SSDI – Disabilities/Survivor's	□ Medicaid
□ HUD	□ Other:_____	□ HUD	□ Other:_____
	□ None of the above		□ None of the above

Family Issues

□ Chronic health problems_____
□ Parent with disabilities_____
□ Parent is incarcerated_____
□ Homelessness_____
□ Physical Isolation_____
□ Substandard Housing_____
□ No transportation_____
□ Violence in the home_____
□ Other_____

Assistance Needed

□ Food
□ Housing
□ Utilities
□ Clothing
□ Health Care

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SECTION 10: EXPECTANT WOMAN INFORMATION FOR PREGNANT WOMEN ONLY

What is your current month of pregnancy? _____

What is the expected due date? _____

To the best of my knowledge, all information provided in this application is true and correct.

_____ _____
Parent/Guardian Signature Date