PMS
PRESBYTERIAN MEDICAL SERVICES

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.

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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:________________________SCHOOL DISTRICT:______________________________

SITE:____________________________ PROGRAM:____________________________________

APPLICATION DATE:_______________ SITE PREFERNCE:_____________________________

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SECTION 1: APPLICANT INFORMATION

Male □
Female □

How did you hear about Head Start/EarlyHead 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. City State Zip

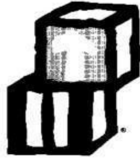
Home Phone#: ___________ Cell Phone #: _____________ Email: ______________________

Child's Race:
□ White
□ American Indian Tribal Affiliation/Census#____________
□ African American/Black
□ Asian
□ Native Hawaiian or Other Pacific Islander
□ Bi-racial

Child's Ethnicity
□ Hispanic or Latino or Spanish Origin
□ Not Hispanic or Latino or Spanish Origin

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? ____

Rev. 3-2019



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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:________________________
____
____
____

Date of Evaluation:________________________

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.

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

Any Behavioral Concerns: □ Yes □ No

If yes, please specify: ____

Indicate Family Type:

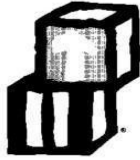
□ Two parent family (married or common law)
□ Single Parent Family: Child lives with_______Mother_____Father
□ Other Relative(s): Specify: _________________________________
□ Foster Family
□ Other Family Type: _____________________________________
□ Living Together

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

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

Number of Adults:___________

Number of Children: _____



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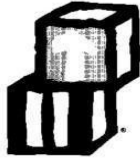
SECTION 4: EDUCATION/EMPLOYMENT INFORMATION

Mother/Guardian's Name: DOB:	Father/Guardian's Name: DOB:
Race: □ Bi-Racial ____________________ □ White □ American Indian or Alaskan Native □ Hawaiian or Other Pacific Islander □ Asian □ Black or African American **Ethnicity:** □ Hispanic or Spanish Origin □ Not Hispanic or Spanish Origin	Race: □ Bi-Racial ____________________ □ White □ American Indian or Alaskan Native □ Hawaiian or Other Pacific Islander □ Asian □ Black or African American **Ethnicity:** □ Hispanic or Spanish Origin □ Not Hispanic or Spanish Origin

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 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 □ Completion Date: __________ **Student?** □ Yes or □ No □ 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 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 □ Completion Date: __________ **Student?** □ Yes or □ No □ Full Time (12+hours) □ Part Time (less than 12 credit hours) Field of Study: ________________________ School: ____________________________



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SECTION 5: CHILD CARE INFORMATION

If applicable, who cares for your child when you are at work or school?

□ Childcare center, please specify: ___________________________________
□ Childcare home please specify: ___________________________________
□ Relative or other adult in **your** home
□ Relative or other adult in **their** home.
□ Other: ____
□ Does not apply

How is the child care paid for:

□ Self-Pay □ Full Price □ Sliding Scale □ Co-Pay
□ Assistance (specify source) ____

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

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SECTION 6: HOUSING INFORMATION

Type of Housing:
□ Mobile Home □ House □ Apartment □ Other

Do you:
□ 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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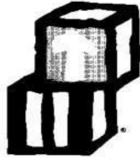
SECTION 8: PROGRAM INFORMATION

Early Head Start (0 to 36 months) □
Head Start (3 to 5 years) □

FOR EHS ONLY:

My preference is:

	PROGRAM SERVICES	EXPLAIN WHY
	Full Day Year Round (times vary)	
	Home Based Services	



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SECTION 9: FAMILY ASSISTANCE INFORMATION

What services are you currently receiving?

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

Family Issues:

□ Chronic Health Problems
□ Parents with Disabilities
□ Parent is Incarcerated
□ Homelessness
□ Physical Isolation
□ Substandard Housing
□ No Transportation
□ Violence in the Home

What Services Do You Need?

□ TANF/CASH Grant
□ WIC/ECHO
□ Medicaid
□ Unemployment Insurance
□ SSDI- Disabilities/Survivor's
□ HUD
□ Food Stamps
□ Other: _________________
□ None of the Above

Emergency Assistance Needed:

□ Food
□ Housing
□ Utilities
□ Clothing
□ Health Care

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SECTION 10: EXPECTANT WOMAN INFORMATION FOR PREGNANT WOMEN ONLY

Would you be interested in our prenatal home based program? □YES □NO

What is your current month of pregnancy? ___________

What is the expected due date? ___________________

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SECTION 11: SIGNATURES

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

____________________________ __________________
Parent/Guardian Signature Date