

PRESBYTERIAN MEDICAL SERVICES
CHILDREN'S SERVICES



Children's Services
Welcome to Early Head Start!
EXPECTANT WOMAN APPLICATION

Program Year _____

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

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

1. Proof of income for the previous 12 months from the date you submit your application, such as, but not limited to the following:

____ Most recent income Tax Form 1040A or 1040 and W-2 forms

____ Pay stubs

____ Computer printout of TANF benefits, SSI

____ Proof of Child Support Benefits

For Office Use Only

Session Requested _____



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

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SECTION 1: APPLICANT INFORMATION **Expectant Woman**

EXPECTANT WOMAN NAME : _____

DOB: _____ Due Date: _____

Mailing Address: _____
Street or PO Box City State Zip

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

Ethnicity:

Bi-racial

White (Non Hispanic)

Black (Non Hispanic)

American Indian Tribal Affiliation/Census # _____

Eskimo

Aleut

Spanish origin (Specify)

Mexican

Japanese

Day time Phone #

Puerto Rican

Filipino

Cuban

Samoan

Hispanic

Guamanian

Other

Asian Indian

Asian Pacific Islander (Specify)

Chinese

Other

Korean

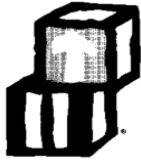
Vietnamese

Hawaiian

Language:

What language is spoken the most in your home? _____

How well do you speak English? Very Well Well Not Well Not at all



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SECTION 2: DISABILITIES INFORMATION

Have you been told by a physician that you have a high risk pregnancy?

YES NO

If yes please list: _____

Date of Evaluation: _____

Who Completed Evaluation: _____

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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

Teen Parent: _____

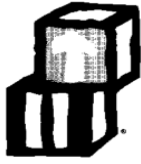
Other Family Type: _____

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

Name	DOB	Relationship to Child	Ethnicity Language	Employed PT/FT	In School PT/FT Grade EHS
1					
2					
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: _____

Father/Guardian's Name _____

Ethnicity:

Ethnicity:

- Bi-racial _____
- White (Non Hispanic)
- Black (Non Hispanic)
- American Indian
Tribal Affiliation/Census # _____
- Eskimo
- Aleut
- Spanish Origin (Specify) _____
- Mexican
- Puerto Rican
- Cuban
- Hispanic
- Asian Pacific Islander (Specify) _____
- Chinese Vietnamese
- Korean Japanese
- Hawaiian Filipino Samoan
- Guamanian Asian Indian Other

- Bi-racial _____
- White (Non Hispanic)
- Black (Non Hispanic)
- American Indian
Tribal Affiliation/Census # _____
- Eskimo
- Aleut
- Spanish Origin (Specify) _____
- Mexican
- Puerto Rican
- Cuban
- Hispanic
- Asian Pacific Islander (Specify) _____
- Chinese Vietnamese
- Korean Japanese
- Hawaiian Filipino Samoan
- Guamanian Asian Indian Other

Language:

Language:

What language is spoken? _____

What language is spoken? _____

Do you speak any other language? _____

Do you speak any other language? _____

Last grade completed: _____ GED: _____

Last grade completed: _____ GED: _____

- Employed
- Full time Part time Seasonal Temp

- Employed
- Full time Part time Seasonal Temp

Employer _____

Employer _____

Name

Name

Address

Address

City

City

Phone

Phone

Student Year round FT 12+ hrs.

Student Year round FT 12+ hrs.

PT less than 12 credit hours

PT less than 12 credit hours

Field of Study: _____

Field of Study: _____

School: _____

School: _____



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SECTION 5: 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 6: TRANSPORTATION INFORMATION

Do you have access to a vehicle: YES NO

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SECTION 7: PROGRAM INFORMATION

Early Head Start (0 to 3 years)

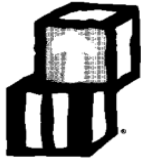
Site Preference: _____

My preference is: (check all that apply)

PROGRAM SERVICES

EXPLAIN WHY

PROGRAM SERVICES	EXPLAIN WHY
<input type="checkbox"/> Home Based Services	



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SECTION 8: FAMILY ASSISTANCE INFORMATION

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

- | | | | |
|--------------------------|---|--|---------------------------------------|
| Receiving | Need | Receiving | Need |
| <input type="checkbox"/> | <input type="checkbox"/> TANF | <input type="checkbox"/> | <input type="checkbox"/> Food Stamps |
| <input type="checkbox"/> | <input type="checkbox"/> Unemployment Insurance | <input type="checkbox"/> | <input type="checkbox"/> WIC/ECHO |
| <input type="checkbox"/> | <input type="checkbox"/> SSI-Disabilities/Survivors | <input type="checkbox"/> | <input type="checkbox"/> Medicaid |
| <input type="checkbox"/> | <input type="checkbox"/> HUD | <input type="checkbox"/> | <input type="checkbox"/> Other: _____ |
| | | <input type="checkbox"/> 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 9: EXPECTANT WOMAN INFORMATION

Current month of pregnancy? _____

Name & Address of Health Care Provider: _____

Name	Street or PO Box	
City	State	Zip

Do you have any medical conditions? YES NO
Specify _____

Do you have any other concerns? YES NO
Specify _____

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

_____ Signature	_____ Date
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