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 #

_____
Day time Phone #

Ethnicity:

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

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: EDCUATION/EMPLOYMENT INFORMATION

Mother/Guardian's Name:_____
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

Language:
What language is spoken?_____
Do you speak any other language?_____

Last grade completed:_____ GED:_____
- ☐ Employed
- ☐ Full time ☐ Part time ☐ Seasonal ☐ Temp

Employer_____
Name
_____
Address
_____
City
_____
Phone

- ☐ Student ☐ Year round ☐ FT 12+ hrs.
- ☐ PT less than 12 credit hours

Field of Study:_____

School: _____

Father/Guardian's Name_____
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

Language:
What language is spoken? _____
Do you speak any other language? _____

Last grade completed: _____ GED:_____
- ☐ Employed
- ☐ Full time ☐ Part time ☐ Seasonal ☐ Temp

Employer_____
Name
_____
Address
_____
City
_____
Phone

- ☐ Student ☐ Year round ☐ FT 12+ hrs.
- ☐ PT less than 12 credit hours

Field of Study: _____

School: _____

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SECTION 5: 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 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
	Home Based Services	

SECTION 8: FAMILY ASSISTANCE INFORMATION

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

Receiving	Need	Receiving	Need
□	□ TANF	□	□ Food Stamps
□	□ Unemployment Insurance	□	□ WIC/ECHO
□	□ SSI-Disabilities/Survivors	□	□ Medicaid
□	□ HUD	□	□ Other:_____
		□ 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