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 Head Start Program. Please complete as accurately and fully as possible to streamline the process.

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

1. Proof of income for the previous 12 months from the date you submit your application, or previous year, such as
   The following (but not limited to)
   ____ Most recent income Tax Form 1040A or 1040 and W-2 forms
   ____ Pay stubs for all jobs
   ____ Computer printout of TANF benefits, 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. ____ Child’s Social Security Card (if applicable)

5. ____ Current Medicaid Card

6. ____ If your child has a diagnosed disability, please submit copies of your child’s IEP IFSP records from the Special Education Program providing services (we can assist you in obtaining these records with your written authorization.)

7. ____ 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 (initial)_____ ☐ Over Income by $______ ☐ Income Eligible ☐ Child Age _____

☐ If over income approved, give reason______________________________________________

__________________________________________

Authorized Personnel Authorised Personnel Authorised Personnel

COUNTY: __________________________ SCHOOLDISTRICT: __________________________

SITE: __________________________ PROGRAM: __________________________

APPLICATION DATE: ______________ How did you hear about Head Start/Early Head Start? __________

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SECTION 1: APPLICANT INFORMATION ☐ Expectant Woman

Male ☐ Female

CHILD’S NAME: ______________________ DATE OF BIRTH: ______________

Parent/Guardian’s Name: ______________________ Child SSN: ______________

Mailing Address: ______________________

Street or PO Box City State Zip

Living Address: ______________________ Home Phone #

____________________________________ Day time Phone #

Child’s Ethnicity:

☐ Bi-racial ☐ Puerto Rican ☐ Filipino

☐ White (Non Hispanic) ☐ Cuban ☐ Samoan

☐ Black (Non Hispanic) ☐ Hispanic ☐ Guamanian

☐ American Indian Tribal Affiliation/Census #_____ ☐ Other ☐ Asian Indian

☐ Eskimo ☐ Asian Pacific Islander (Specify)

☐ Aleut ☐ Chinese ☐ Other

☐ Spanish origin (Specify) ☐ Korean

☐ Mexican ☐ Vietnamese

☐ Japanese ☐ Hawaiian

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. 4-.13
SECTION 2: DISABILITIES INFORMATION

Has your child been diagnosed with or suspected of having a disability or developmental delay? □ YES □ NO

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

Complications at Birth:

If yes please list:_____________________

□ Low birth weight

□ Premature

□ Prenatal exposure to drugs, medications, etc. known to be associated with developmental delay.

Date of Evaluation: ____________________

Who Completed Evaluation: ________________________________

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: ________________________________

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

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Relationship to Child</th>
<th>Ethnicity</th>
<th>Employed PT/FT</th>
<th>PT/FT Grade</th>
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</tr>
</tbody>
</table>

Number of Adults:_______ Number of Children: _______
SECTION 4: EDUCATION/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 Hours per Week_________
- □ 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 Hours per week_________
- □ 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:_____________________________________

Rev. 4-13
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 (specify source) _______________________________________

Do you need child care year round?  ☐ ☐ YES, why? _______________________
- ☐ NO, why? ______________________________________________________

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

SECTION 7: TRANSPORTATION INFORMATION
Do you have access to a vehicle:  ☐ ☐ YES  ☐ ☐ NO

SECTION 8: PROGRAM INFORMATION
Early Head Start (0 to 3 years)  ☐
Head Start (3 to 5 years)  ☐

Site Preference: _________________________________

My preference is: (check all that apply)

<table>
<thead>
<tr>
<th>PROGRAM SERVICES</th>
<th>EXPLAIN WHY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Day Year Round (times vary)</td>
<td></td>
</tr>
<tr>
<td>Full Day/School Year (times vary)</td>
<td></td>
</tr>
<tr>
<td>Part Day (4-6 hrs. per day) School Year</td>
<td></td>
</tr>
<tr>
<td>Morning Session (3 ½ hrs.) School Year</td>
<td></td>
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<tr>
<td>Afternoon Session (3 ½ hrs/) School Year</td>
<td></td>
</tr>
<tr>
<td>Home Based Services</td>
<td></td>
</tr>
</tbody>
</table>

Rev. 4-.13
SECTION 9: FAMILY ASSISTANCE INFORMATION

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

<table>
<thead>
<tr>
<th>Receiving Income</th>
<th>Need</th>
<th>Receiving Assistance</th>
<th>Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>□□</td>
<td>□ TANF</td>
<td>□□</td>
<td>□ Food Stamps</td>
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<tr>
<td>□□</td>
<td>□ Unemployment Insurance</td>
<td>□□</td>
<td>□ WIC/ECHO</td>
</tr>
<tr>
<td>□□</td>
<td>□ SSI-Disabilities/Survivors</td>
<td>□□</td>
<td>□ Medicaid</td>
</tr>
<tr>
<td>□□</td>
<td>□ HUD</td>
<td>□□</td>
<td>□ Other: ____</td>
</tr>
</tbody>
</table>

Family Issues
□□ Chronic health problems________
□□ Parent with disabilities_______
□□ Parent is incarcerated_______
□□ Homelessness________
□□ Physical Isolation________
□□ Substandard Housing________
□□ No transportation_______
□□ Violence in the home________

□□ Other________________________________________

SECTION 10: EXPECTANT WOMAN INFORMATION FOR PREGNANT WOMEN ONLY

Current month of pregnancy? ______________________
What is the expected due date? ______________________

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

Rev. 4-.13