

## 2017-2018 Application

Legal Name of Child:	Who does this child live with < 50% ?
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Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	Child's Date of Birth:	Child's Age on 9/1/2017:
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Child's Home Address:	Was this child referred for services by Child Welfare Agency Yes: <input type="checkbox"/> No: <input type="checkbox"/> If Yes, What County?
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City:	State:	Zip:	County:
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Name of Primary Caregiver:	Name of Secondary Caregiver:
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Relationship to Child:	Relationship to Child:
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Phone Number:	Phone Number:
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Additional Phone:	Additional Phone:
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### What Program(s) Are You Interested In For This Child?

<p><b>Early Head Start (Ages 0-3)</b></p> <table style="width: 100%;"> <tr> <td style="width: 5%; text-align: center;"><input type="checkbox"/></td> <td>Early Head Start 7:45-2:00</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>Home Based Program</td> </tr> </table>	<input type="checkbox"/>	Early Head Start 7:45-2:00	<input type="checkbox"/>	Home Based Program	<p><b>Head Start (Ages 3-5)</b></p> <table style="width: 100%;"> <tr> <td style="width: 5%; text-align: center;"><input type="checkbox"/></td> <td>Head Start 7:45-2:00</td> </tr> </table> <p style="text-align: center; font-size: small;">**Child <b>MUST</b> be 3 by September 1st of 2017 to be eligible for Head Start (ages 3-5)**</p>	<input type="checkbox"/>	Head Start 7:45-2:00
<input type="checkbox"/>	Early Head Start 7:45-2:00						
<input type="checkbox"/>	Home Based Program						
<input type="checkbox"/>	Head Start 7:45-2:00						

### What Is Your Child's Ethnicity? (check all that apply)

<input type="checkbox"/> Asian	<input type="checkbox"/> Native American/Alaskan Native	<input type="checkbox"/> Bi-Racial/Multi-Racial
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Native Hawaiian	
<input type="checkbox"/> Other: _____	<input type="checkbox"/> White	

Is Your Child Hispanic/Latino	<input type="checkbox"/> Yes <input type="checkbox"/> No
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My Child Has Tribal Affiliation With: (list tribe)	Name of Person Enrolled:
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Person Enrolled: <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandparent	Verified on: _____ By: _____
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\*\*OFFICE USE ONLY\*\*

### My Child Is Currently Receiving: (check all that apply)

<input type="checkbox"/> Child Care Assistance	<input type="checkbox"/> Supplemental Security Income (SSI)	<input type="checkbox"/> WIC	
<input type="checkbox"/> MFIP- Cash Assistance	<input type="checkbox"/> Food Stamps (SNAP)		

**Application MUST be returned to the Head Start Office with Income Verification. Please bring one of the following documents when you return the application:**

- Pay Stub
- Public Assistance ID Number
- W-2
- Tax Forms

**CONTINUED ON BACK**



Is this child currently receiving services for a disability?  Yes  No

Medical  Physical  Emotional  Educational Special Needs

Other: \_\_\_\_\_

Do you have concerns about this child's development?  Yes  No

Speech  Learning  Health  Physical  Emotional

Psychological  Behavioral  Other: \_\_\_\_\_

How many people live in your household (including all adults and children)? \_\_\_\_\_

Is this child currently in Foster Care?  Yes  No If yes, what county? \_\_\_\_\_

Name of Social Worker? \_\_\_\_\_

My Household currently has NO INCOME:  Yes **\*\*If yes a No Income Form MUST be filled out\*\***

My Household receives a Tribal Per-capita Payment:  Yes  No Amount: \_\_\_\_\_

Please check ALL that apply for your child. This information will only be used to assist us in determining enrollment priority along with income eligibility

<input type="checkbox"/>	Transitioning Student from Early Head Start to Head Start
<input type="checkbox"/>	Single Parent
<input type="checkbox"/>	Teen Parent
<input type="checkbox"/>	Parent/Guardian(s) in school
<input type="checkbox"/>	Parent/Guardian(s) has at least a part time job
<input type="checkbox"/>	Parent/Guardian(s) needs/wants high school diploma/GED
<input type="checkbox"/>	No prenatal care
<input type="checkbox"/>	Child with serious health issue
<input type="checkbox"/>	Child has history of neglect
<input type="checkbox"/>	Alcohol/drug abuse in child's family
<input type="checkbox"/>	Domestic violence history in child's family
<input type="checkbox"/>	Multiple families under one roof
<input type="checkbox"/>	Family caring for elder in home
<input type="checkbox"/>	Child has identified disability/special need/mental health issue
<input type="checkbox"/>	Family history of diabetes
<input type="checkbox"/>	Family is homeless-lack a fixed, regular, and adequate night time residence
<input type="checkbox"/>	Child of Incarcerated Parent

Caregiver filling out application: \_\_\_\_\_  
Signature

Date: \_\_\_\_\_

Please print name: \_\_\_\_\_

Staff Use Only:	
Received by: _____	Date: _____