

## 2016-2017 Application

Legal Name of Child: \_\_\_\_\_ Who does this child live with < 50% ? \_\_\_\_\_

Sex: Male  Female  Child's Date of Birth: \_\_\_\_\_ Child's Age on 9/1/2016: \_\_\_\_\_

Childs Home Address: \_\_\_\_\_ Was this child referred for services by Child Wefare Agency  
Yes:  No:  If Yes, What County? \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Name of Primary Caregiver: \_\_\_\_\_ Name of Secondary Caregiver: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Additional Phone: \_\_\_\_\_ Additional Phone: \_\_\_\_\_

### What Program(s) Are You Interested In For This Child?

#### Early Head Start (Ages 0-3)

<input type="checkbox"/>	Part Day 7:45-2:00
<input type="checkbox"/>	Full Day Includes Child Care
<input type="checkbox"/>	Home Based Program

#### Head Start (Ages 3-5)

<input type="checkbox"/>	Part Day 7:45-2:00
<input type="checkbox"/>	Full Day Includes Child Care

**\*\*Child MUST be 3 by September 1st of 2016 to be eligible for Head Start (ages 3-5)\*\***

### 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 You Child Hispanic/Latino  Yes  No

My Child Has Tribal Affiliation With: (list tribe) \_\_\_\_\_ Name of Person Enrolled: \_\_\_\_\_

Person Enrolled:  Child  Parent  Grandparent  
Verified on: \_\_\_\_\_ By: \_\_\_\_\_

**\*\*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"/>	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

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

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

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

Staff Use Only:

Received by: _____	Date: _____
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