



LSF - Head Start/ Early Head Start Program APPLICATION

I would like to apply for: Head Start Early Head Start

Date Received:

Enrollment Date:

CHILD'S INFORMATION

School/Center:		Classroom/FCCH Assignment:	
Child's Legal Name (Last)	(First)	Date of Birth	Sex: M/F
Language Spoken at Home: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Creole <input type="checkbox"/> Other		Interpreter needed: Yes No	
Race: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Amer. Indian <input type="checkbox"/> Native Amer. Asian/Pac. <input type="checkbox"/> Pacific Islander		Was child referred to Head Start by another Agency? No Yes If yes, describe:	
Ethnicity: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other			

PARENTS' INFORMATION

First and Last Name	Lives with the child	Date of Birth	Race	Language Spoken	Last Grade Completed	Hours Worked	Occupation
Mother							
Father							
Guardian Relationship to Child: (Check One) Grandfather Grandmother Other Foster Aunt							
Living Address:		City:	Zip Code:	Apt #	Lot #	Unit #	
Mailing Address:		City:	Zip Code:	Apt #	Lot #	Unit #	
My Living Address is:		My own Residence Living with Relative/Friends Other _____		Parent Military Deployment		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mother's Phone #: _____ / _____ / _____		Father's Phone #: _____ / _____ / _____		Home Cell Other		Home Cell Other	
Mother/Guardian Employer's Name: _____		Work # _____		City _____		Zip Code _____	
Father/Guardian Employer's Name: _____		Work # _____		city _____		Zip Code _____	
Parent Status (in household): <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster			Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed				
Number in Family: _____		Number of Family Members you Support: _____		Have you ever had a child in HS/EHS? <input type="checkbox"/> Yes <input type="checkbox"/> No			

OTHER FAMILY MEMBERS IN HOUSEHOLD YOU SUPPORT

First & Last Name	Date of Birth	Sex	Relationship to Child	Child or Adult	Is the adult an "Authorized Caregiver" & Provides Support?	
		M F			NO	YES
		M F			NO	YES
		M F			NO	YES
		M F			NO	YES
		M F			NO	YES
		M F			NO	YES

EMERGENCY CONTACT INFORMATION & PERSON(S) AUTHORIZED TO PICK UP CHILD FROM THE SCHOOL/CENTER

Name of Adult	Address	Phone	Relationship

COMPLETE BOTH SIDES OF APPLICATION

Turn Over →→→

CHILD'S DISABILITIES INFORMATION

Disability Status: Diagnosed Suspected/Concern None Please provide documentation: IEP IFSP Evaluation/Doctors Note
 Does your child have concerns in the following areas: Vision Developmental Hearing Speech Other _____

CHILD'S MEDICAL INFORMATION

Medical Diagnosis: _____ Any prescribed medication(s)? _____
 Diagnosed Asthma Diagnosed Allergies (Food, Insect, Environmental) Other _____
 Medical Concern(s) _____ Nutrition Concern(s): Yes No Special Diet: _____

MEDICAID STATUS: Eligible Ineligible Applied Former Medicaid # _____ HMO Yes No
 Medical Insurance: Private S-CHIP Dental Insurance: Yes No Name: _____ Medical/Dental Provider _____

Any specific family need or crisis? No Yes (If yes, describe)

PUBLIC ASSISTANCE

NON-CASH **FOOD STAMPS** Yes No **CASH** Are you receiving Child Care Assistance? Yes No
 Receiving WIC Yes No AFDC/WAGES Yes No SSI/SSD Yes No

INCOME (BEFORE TAXES AND LIVING IN THE HOME)

MOTHER/LEGAL GUARDIAN/RELATIVE CAREGIVER

Employed Yes No **Employed** Full Time Part Time **Gross Income:** \$ _____ **Paid:** _____ Weekly _____ Biweekly _____ Monthly
 Attends School (Name): _____ **Student Status:** Full Time Part Time

FATHER/LEGAL GUARDIAN/RELATIVE CAREGIVER

Employed Yes No **Employed** Full Time Part Time **Gross Income:** \$ _____ **Paid:** _____ Weekly _____ Biweekly _____ Monthly
 Attends School (Name): _____ **Student Status:** Full Time Part Time

OTHER INCOME (DOCUMENTS REQUIRED)

Social Security Benefits \$ _____ SSI \$ _____ AFDC/WAGES \$ _____
 Unemployment \$ _____ Weekly _____ Biweekly _____ Monthly Foster Care \$ _____
 Child Support \$ _____ Weekly _____ Biweekly _____ Monthly Other Income _____

PLEASE READ BEFORE SIGNING:

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT ALL INCOME IS REPORTED. I UNDERSTAND THAT THIS INFORMATION IS BEING GIVEN TO DETERMINE ELIGIBILITY FOR A FEDERAL PROGRAM AND WILL BE VERIFIED FOR ACCURACY. I UNDERSTAND THAT DELIBERATE MISREPRESENTATION OF THE INFORMATION MAY SUBJECT ME TO WITHDRAWAL FROM THE PROGRAM AND PROSECUTION UNDER APPLICABLE STATE AND FEDERAL LAWS.

PARENT SIGNATURE: _____ **DATE:** _____

E-mail Address: _____

IN ACCORDANCE WITH THE AMERICANS WITH DISABILITIES ACT, THIS PROGRAM DOES NOT DISCRIMINATE BASED ON DISABILITY.

!!! STOP !!!

DO NOT WRITE IN THIS AREA -- FOR OFFICE USE ONLY

Application Accepted By: _____

ELIGIBILITY DETERMINATION RECORD

DESCRIPTION	(PTS)	DESCRIPTION	(PTS)
Parental Status:		Required Consideration:	
Income:		Migrant Seasonal:	
Age:		Agency Consideration:	
		Face to Face Interview <input type="checkbox"/>	
		Phone Interview <input type="checkbox"/>	
		Total Points:	

Eligibility Comments:

TOTAL EARNED INCOME (Documented)	TOTAL OTHER INCOME	CRITERIA ENROLLED UNDER
PREVIOUS 12 MONTHS INCOME (COMPUTED IN ONE OF THE FOLLOWING WAYS):	TANF \$ _____ SSI \$ _____	____ A. Age (Documentation _____)
1. Mother's Earned Inc. \$ _____ Doc. _____	Social Security Benefits \$ _____	____ B. Income Eligible (below 100%)
2. Father's Earned Inc. \$ _____ Doc. _____	Veteran's Benefits \$ _____	____ C. Public Assistance (TANF, SSI, Subsidized CC)
3. Guardian's Earned Inc. \$ _____ Doc. _____	Child Support \$ _____	____ D. Documented Stress in the Home: (Identify) _____
Total Earned Income: \$ _____	Unemployment Compensation \$ _____	____ E. 101%-130% _____ F. Foster
	Other \$ _____ Source _____	____ G. McKinney-Vento _____ H. Over Income
	Documentation _____	
	Total Other Income \$ _____	
Gross Income \$ _____	# in Family _____	Income Time Frame: _____

Documents Reviewed and Verified by: _____ **Date:** _____
 (Family & Community Engagement Specialist)

FACE Manager/Coordinator/Supervisor Signature: _____ **Date:** _____