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 ad 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.

PRESBYTERIAN MEDICAL SERVICES
CHILDREN'S SERVICES
A-1a

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 **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**

□ 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:_____
Street or County Rd. Home Phone #

_____
Day time Phone #

Child's 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
□ Filipino
□ Samoan
□ Guamanian
□ Other □ Asian Indian
□ Asian Pacific Islander (Specify)
□ Chinese □ Other
□ Korean
□ Vietnamese
□ 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? _____

SECTION 2: DISABILITIES INFORMATION

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

If yes please list:_____
_____
_____
_____

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

Complications at Birth:

□☐ Low birth weight

□☐ Premature

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

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

□ ☐ Other Relative (s): Specify: _____

□☐ Foster Family

□☐ 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	PT/FT Grade EHS
1						
2						
3						
4						
5						
6						
7						
8						

Number of Adults: _____ **Number of Children: _____**

PRESBYTERIAN MEDICAL SERVICES
CHILDREN'S SERVICES
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PMS

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 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: _____

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? _____
□ N O, why? _____

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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

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SECTION 7: TRANSPORTATION INFORMATION

Do you have access to a vehicle: □□ YES □□ NO

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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)

	PROGRAM SERVICES	**EXPLAIN WHY**
	Full Day Year Round (times vary)	
	Full Day/School Year (times vary)	
	Part Day (4-6 hrs.per day) School Year	
	Morning Session (3 ½ hrs.) School Year	
	Afternoon Session (3 ½ hrs/) School Year	
	Home Based Services	

SECTION 9: 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 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