

HEAD START & EARLY HEAD START ENROLLMENT APPLICATION

THE CHILD'S INFORMATION						<input type="checkbox"/> EHS-CCP	<input type="checkbox"/> EHS	<input type="checkbox"/> HS	<input type="checkbox"/> LIFT		
Child's Legal Name		First	Middle Initial	Last							
Child's Place of Birth (City, State)				Child's DOB (mm/dd/yyyy)			Sex				
Child's Ethnicity		Child's Race			Child's Primary Language			Child's Secondary Language			
Latino <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Biracial/ Multi <input type="checkbox"/> Nat. Amer. <input type="checkbox"/> Asian <input type="checkbox"/> Other			<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other			<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other			
THE CHILD'S HOUSEHOLD FAMILY INFORMATION											
1 Primary adult name			Latino?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Primary Language if different from child			Secondary Language if Different from child		
2 Secondary adult (if any)			Latino?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Marital Status:			Parental Status:		
Race			Race			<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			<input type="checkbox"/> One parent <input type="checkbox"/> Two parents <input type="checkbox"/> Foster parent		
Residential Address						Mailing Address (if different from Residential Address)					
City		State CA		Zip Code		City		State		Zip Code	
Primary Phone Number (including area code)				Home <input type="checkbox"/>	Cell <input type="checkbox"/>	Other Phone (including area code)			Home <input type="checkbox"/>	Work <input type="checkbox"/>	Message <input type="checkbox"/>
Total in Family _____		Ok to text? YES <input type="checkbox"/> NO <input type="checkbox"/>		Ok to email? YES <input type="checkbox"/> NO <input type="checkbox"/>		Current Housing: <input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Homeless <input type="checkbox"/> Other _____					
Is your child related to a Preschool Services Department Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No						If not homeless, date you moved in _____					
Employee Name & Relationship to child: _____ Site: _____						Previous Housing: <input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Homeless <input type="checkbox"/> Other _____					
Email Address: _____											
ELIGIBILITY INFORMATION											
Family Receives:				Does Child Have Insurance? Check if applicable:				Does Family Have Medical Insurance?			
SSI YES <input type="checkbox"/> NO <input type="checkbox"/>				<input type="checkbox"/> Medi-Cal <input type="checkbox"/> IEHP <input type="checkbox"/> Healthy Families <input type="checkbox"/> Emergency <input type="checkbox"/> Other <input type="checkbox"/> None				<input type="checkbox"/> Yes <input type="checkbox"/> No			
TANF/CalWORKS YES <input type="checkbox"/> NO <input type="checkbox"/>											
Does family receive WIC? <input type="checkbox"/> Yes <input type="checkbox"/> No				Does Family Receive CalFRESH (EBT)? <input type="checkbox"/> Yes <input type="checkbox"/> No				Does Child Have Dental Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
How did you hear about us? <input type="checkbox"/> Community Event <input type="checkbox"/> Flyer/Poster <input type="checkbox"/> School District <input type="checkbox"/> Community Partner Referral <input type="checkbox"/> Former Parent <input type="checkbox"/> Other Head Start <input type="checkbox"/> State Preschool <input type="checkbox"/> Facebook <input type="checkbox"/> Local Community Agency Referral <input type="checkbox"/> Public Advertisement <input type="checkbox"/> Family Friend <input type="checkbox"/> Mailings <input type="checkbox"/> Public Service Announcements (TV/Radio) <input type="checkbox"/> Online <input type="checkbox"/> Other											
PARENT AND/OR GUARDIAN						INCOME SOURCE					
1						<input type="checkbox"/> Employment <input type="checkbox"/> Disability <input type="checkbox"/> Unemployment Benefits <input type="checkbox"/> Other					
2						<input type="checkbox"/> Employment <input type="checkbox"/> Disability <input type="checkbox"/> Unemployment Benefits <input type="checkbox"/> Other					
PRENATAL INFORMATION											
<input type="checkbox"/> N/A		<input type="checkbox"/> Pregnant before Enrollment			<input type="checkbox"/> First Pregnancy			Expected delivery date: _____			
ADULT HOUSEHOLD FAMILY MEMBER INFORMATION (18 and older only) (Please only include adults in the household supported by the income of the parent.)											
(Enter Primary Adult First) First & Last Name		Date of Birth	How Related to Applicant	Sex	Education Level	Employment circle one:			School/Training circle one:		
1						FT PT N/A			FT PT N/A		
2						FT PT N/A			FT PT N/A		
3						FT PT N/A			FT PT N/A		
4						FT PT N/A			FT PT N/A		

First & Last Name of Children in Home	How Related to Applicant	Date of Birth	Sex	Notes
1	Applied Child			
2				
3				
4				
5				
6				

INFORMATION

At least one parent/guardian is a member of the United States military on active duty Yes No

At least one parent/guardian is a veteran of the United States military Yes No

What type of transportation do you use? Check one. Car Bus Walk Other

If available, is a Head Start school bus needed? Yes No If needed, why?

Children with special needs may receive priority for Head Start enrollment. Your disclosure of this information is strictly voluntary.

- Does your child have a disability? _____ (If no, please go to question #6)
- Type of special need or disability _____
- Has the disability been professionally diagnosed? (If yes, at what age _____? By whom? _____)
- Does the child have an IFSP/IEP? _____
- Is the child receiving special services for the disability? _____
- In your opinion, does your child have a special need that has not yet been diagnosed?
If yes, please explain: _____

Certification: I certify that this information is true. If any part is false, my participation in this agency's program may be terminated. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Children and pregnant mothers that are determined to be eligible for the Early Head Start program are eligible until the child turns 3 years old (4 years old if the child is in family child care).

Applicant Signature : _____ **Date:** _____

TO BE COMPLETED BY STAFF

Initial Enrollment Program Year: 2019-2020	Center Name: _____	Family ID: _____ Child ID: _____	First Day Child Attended Class (Entry): _____
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Acceptance Status (circle): Accept Denied
Program Type: EHS HS
 LIFT EHS-CCP
Program Option: Home Base Full Day Part Day

Income Eligibility (select only one): <input type="checkbox"/> Income (below federal poverty guidelines) <input type="checkbox"/> Over-income Documents Verified (select as many as apply): <input type="checkbox"/> Check Stub <input type="checkbox"/> W2 <input type="checkbox"/> Written Statement from Employer <input type="checkbox"/> TANF/CalWORKs <input type="checkbox"/> SSI <input type="checkbox"/> Unemployment <input type="checkbox"/> Document of no income <input type="checkbox"/> Other _____ Total Annual Income: \$ _____	Categorical Eligibility (select one): <input type="checkbox"/> Homeless <input type="checkbox"/> Foster Care Documents Verified (select one): <input type="checkbox"/> Foster Care Reimbursement <input type="checkbox"/> Statement from homeless services provider <input type="checkbox"/> Other _____	EHS/CCP ONLY: CD 9600 date: _____ First date of subsidized service: _____
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Birth Verified By: Birth Certificate Travel Passport
 Medi-cal Card Other _____
Age by September 1st: _____ **Months at time of Enrollment (EHS & EHS-CCP only):** _____

Verifying Staff Member Signature: _____ **Print Name:** _____ **Date:** _____

Parent Signature (2nd Year): _____ **Date:** _____

Parent confirms eligibility for 2nd year of Head Start based on Head Start Regulations (1302.12(i)(1))

In-person Interview Phone Interview **Note(s):** _____
 Staff signature _____
 Date: _____