



Head Start

DAEOC Head Start/Early Head Start 2018-2019 Enrollment Application

Early
Head Start

Application # _____

Program: ☐ Head Start ☐ Early Head Start Center ☐ Early Head Start Home Based Center: _____

Have you previously filled out an application for Head Start or Early Head Start? ☐ Yes ☐ No Does the enrolling child have a sibling in the Head Start or Early Head Start Program ☐ Yes ☐ No

Name on Previous Application: _____ Center: _____

Enrolling Child

Child's Name: _____ Child's Date of Birth: _____

Primary Caregiver General Information

First Name: _____ M. I. _____ Last Name: _____

Gender ☐ M ☐ F Application Date: _____ Birth Date: _____ Receiving WIC ☐ Y ☐ N

Language ☐ English ☐ Spanish ☐ Other Other Language: _____ ☐ Food Stamp/SNAP

Ethnicity _____ Race _____ ☐ Asian ☐ Bi-racial/Multi-racial ☐ Black ☐ Other
☐ Hispanic/Latino ☐ Native American ☐ Caucasian ☐ Indian

Education Level

☐ Bachelor or Advanced Degree ☐ Some High School ☐ Employed Full-Time ☐ Unemployed
☐ College degree or Training Certificate ☐ No High School ☐ Employed Part-Time ☐ Retired
☐ High School Graduate ☐ GED ☐ Self Employed ☐ Disabled
☐ Some College/Vocational/Associates Degree ☐ ESL ☐ Job Training or in School

Employment Status

Employer/School Address: _____ ☐ Veteran of the United States Military
☐ Member of US Military on Active Duty

Phone (Home) _____ Phone (Cell) _____ Consents to receive text messages ☐ Y ☐ N Carrier: _____ Phone (Work/School) _____

Email: _____ Home Address: _____ City: _____

County: _____ State: _____ Zip Code: _____ Mailing Address: ☐ Same

Family Structure ☐ Single Parent ☐ Two Parent Parents/Guardians Best Descriptor ☐ Mother (biological, adoptive, stepmother) ☐ Grandparent
☐ Father (biological, adoptive, stepfather) ☐ Foster Parent not including relative
☐ Parents (biological, adoptive, stepparents)
☐ Relative (other than grandparent)

in Family: _____ Medical Insurance ☐ Yes ☐ No Current Housing ☐ Homeless ☐ Rent ☐ Own ☐ Other Previous Housing ☐ Homeless ☐ Rent ☐ Own ☐ Other
in Household: _____

*****Early Head Start Only*****

☐ Pregnant Mother Before Enrollment Expected Delivery Date: _____ ☐ Proof of Pregnancy

☐ Pregnant 1st Trimester ☐ Pregnant 2nd Trimester ☐ Pregnant 3rd Trimester DCN # _____

Secondary Caregiver General Information - Must be legally related to child☐ No Secondary Caregiver (Skip to page 2)

First Name: _____ M. I. _____ Last Name: _____

Gender ☐ M ☐ F Birth Date: _____ Legal Relationship: _____

Language ☐ English ☐ Spanish ☐ Other Other Language: _____

Ethnicity _____ Race _____ ☐ Asian ☐ Bi-racial/Multi-racial ☐ Black ☐ Other
☐ Hispanic/Latino ☐ Native American ☐ Caucasian ☐ Indian

Education Level

☐ Bachelor or Advanced Degree ☐ Some High School ☐ Employed Full-Time ☐ Unemployed
☐ College degree or Training Certificate ☐ No High School ☐ Employed Part-Time ☐ Retired
☐ High School Graduate ☐ GED ☐ Self Employed ☐ Disabled
☐ Some College/Vocational/Associates Degree ☐ ESL ☐ Job Training or in School

Employment Status

Employer/School Address: _____ ☐ Veteran of the United States Military
☐ Member of US Military on Active Duty

Phone (Home) _____ Phone (Cell) _____ Consents to receive text messages ☐ Y ☐ N Carrier: _____ Phone (Work/School) _____

Email: _____ Home Address: _____ ☐ Same as Primary Caregiver



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Child Application

<input type="checkbox"/> Applicant for 2018-2019		Desired Center 1:		Desired Center 2:	
Child's First Name:			M. I.	Child's Last Name:	
Application Date:		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date:		<input type="checkbox"/> Early 3 Yr old after 7/31
Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other			Other Language:		
Ethnicity	Race	<input type="checkbox"/> Asian <input type="checkbox"/> Bi-racial/Multi-racial <input type="checkbox"/> Black <input type="checkbox"/> Other <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native American <input type="checkbox"/> Caucasian <input type="checkbox"/> Indian			

Eligibility Information

<input type="checkbox"/> Parent 19 years or younger <input type="checkbox"/> Homeless <input type="checkbox"/> Guardian other than parents **MUST HAVE LEGAL DOCUMENTS** <input type="checkbox"/> Disabled Parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Grandparent	
Relationship to Primary Caregiver:	Relationship to Secondary Caregiver:

Additional Eligibility Information

<input type="checkbox"/> Child Protective Services	<input type="checkbox"/> Severe illness of household member within the last year
<input type="checkbox"/> Child is a sibling of <i>currently</i> enrolled HS/EHS child	<input type="checkbox"/> Death of household member within the past year
<input type="checkbox"/> One/Both parents/guardian has NO high school diploma/GED	<input type="checkbox"/> One/Both parents <i>currently</i> incarcerated
<input type="checkbox"/> Non-English speaking	<input type="checkbox"/> One/Both parents on probation/parole

Other - CHECK ONLY ONE

- ☐ Child **CURRENTLY** enrolled in Early Head Start
- ☐ Completed 12 **Consecutive** Months of Early Head Start
- ☐ Completed 24 **Consecutive** Months of Early Head Start
- ☐ Completed 36 **Consecutive** Months of Early Head Start

Employment/School/Training - CHECK ONLY ONE

- ☐ One/Both parents/guardian are attending school/training/working **FULL-TIME**
- ☐ One/Both parents/guardian are attending school/training/working **PART-TIME**

Disability Eligibility Information - Special Needs that suggest Learning Delays

*****CHECK ONLY ONE*****

Disability Documented and Verified By:	<input type="checkbox"/> Current Certified IEP (Individualized Education Program)	<input type="checkbox"/> Physician Statement
	<input type="checkbox"/> Current Certified IFSP (Individualized Family Service Plan)	<input type="checkbox"/> Suspected Per Parent Report

Program Information

Program Model	Program Options	Hours Per Day
<input type="checkbox"/> Head Start	<input type="checkbox"/> Center Base 4 days per week part time	<input type="checkbox"/> ____
<input type="checkbox"/> Early Head Start	<input type="checkbox"/> Center Base 5 days per week	<input type="checkbox"/> ____
<input type="checkbox"/> Early Head Start	<input type="checkbox"/> Home Based	<input type="checkbox"/> ____

☐ Referred to HS/EHS Services by Child Welfare Agency

Important Documentation

Application Information	Enrollment Information	Program provides at a later date
<i>Copies are needed BEFORE application is considered complete</i>	<i>Copies are needed AFTER child is enrolled in the Program</i>	<i>Provided AFTER child is enrolled in the Program</i>
<ul style="list-style-type: none"> • Proof of Age • Proof of Income 	<ul style="list-style-type: none"> • Immunization record • Medical or Insurance Card <ul style="list-style-type: none"> • IEP/IFSP • Copy of Medical Concerns 	<ul style="list-style-type: none"> • Forms to be completed by a Doctor/Dentist <ul style="list-style-type: none"> • Information to be acknowledged • Permission to be given



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Child's Name:

Child's Date of Birth:

Other Family Members - Supported by Caregivers income (If Applicable)

First Name:

Last Name:

Birth Date:

Ethnicity

Race

☐ Asian☐ Bi-racial/Multi-racial☐ Black☐ Other☐ Hispanic/Latino☐ Native American☐ Caucasian☐ IndianGender ☐ M ☐ F

Relationship to Child:

Supported by Caregivers income? ☐ Y ☐ N

First Name:

Last Name:

Birth Date:

Ethnicity

Race

☐ Asian☐ Bi-racial/Multi-racial☐ Black☐ Other☐ Hispanic/Latino☐ Native American☐ Caucasian☐ IndianGender ☐ M ☐ F

Relationship to Child:

Supported by Caregivers income? ☐ Y ☐ N

First Name:

Last Name:

Birth Date:

Ethnicity

Race

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Relationship to Child:

Supported by Caregivers income? ☐ Y ☐ N

First Name:

Last Name:

Birth Date:

Ethnicity

Race

☐ Asian☐ Bi-racial/Multi-racial☐ Black☐ Other☐ Hispanic/Latino☐ Native American☐ Caucasian☐ IndianGender ☐ M ☐ F

Relationship to Child:

Supported by Caregivers income? ☐ Y ☐ N**Eligibility Verification - Staff Use Only****Documentation Copied to Verify Age**☐ Certified Birth Certificate☐ Medical Card☐ Physical☐ Hospital Birth Certificate☐ Shot Record☐ Other**Documentation Copied to Verify Income**☐ W-2☐ Income Tax Form☐ Foster Care Documentation☐ SSI☐ TANF Document☐ Unemployment Documentation☐ Check Stub☐ Family Income Statement Form☐ Written Statement from Employer(s)☐ Other

**Is child currently AGE eligible
to enroll in:**

Head Start/Early Head Start

☐ Yes ☐ No

**Is child currently INCOME eligible
to enroll in:**

Head Start/Early Head Start

☐ Yes ☐ No (Over Income)

I certify that I have examined the following age and income documentation of the above named applicant and any and all decisions were in accordance with the Head Start Federal Guidelines.

X

Staff Name & Title that verified eligibility

X

Date of verified eligibility



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*** MAKE A COPY OF THIS PAGE TO KEEP ON THE BUS***

Child Transportation

Child's Name:	Date:	<input type="checkbox"/> Bus	<input type="checkbox"/> Parent	<input type="checkbox"/> Other
Center Name:	Center Director:			
Does this Child <u>Require</u> Transportation HS ONLY	Pick Up Location:			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Drop Off Location:			

Child Authorization/Emergency-Release Pick-Up

Primary and/or Secondary Caregiver(s)		Name:	
Phone (Home)	Phone (Cell)	Phone (Work/School)	
Address		Relationship to Child	
Language	Release To: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Contact <input checked="" type="checkbox"/> Y <input type="checkbox"/> N	
Name:	Phone(s) → Home:	Cell:	Work:
Address:		Relationship to Child:	
Language	Release To: <input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Contact <input type="checkbox"/> Y <input type="checkbox"/> N	
Name:	Phone(s) → Home:	Cell:	Work:
Address:		Relationship to Child:	
Language	Release To: <input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Contact <input type="checkbox"/> Y <input type="checkbox"/> N	
Name:	Phone(s) → Home:	Cell:	Work:
Address:		Relationship to Child:	
Language	Release To: <input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Contact <input type="checkbox"/> Y <input type="checkbox"/> N	
Restricted From Picking-up:	Reason:	<input type="checkbox"/> Court Order <input type="checkbox"/> Court Order Attached	
Legal Documents Required			

Child Medical Record

Family Doctor/Clinic Name:			Phone:	
Family Dentist/Clinic Name:			Phone:	
Insurance Co:	Group #	Policy #	DCN#	<input type="checkbox"/> WIC <input type="checkbox"/> Food Stamps
Dental Coverage <input type="checkbox"/> Y <input type="checkbox"/> N	Name of Dental Insurance Co.			

Health History and/or Critical Health Notes (Allergies, Special Needs, Habits, Language)

<p>Should my child become seriously ill or injured while under the care of the DAEOC Head Start/Early Head Start Program and I cannot be reached, HS/EHS has my permission to transport and/or seek necessary treatment for my child at the local physician's office and/or Emergency Room.</p> <p>Guardian Signature: X _____ Date: _____</p> <p>Staff Signature: X _____ Date: _____</p> <p>It is our policy to comply with all applicable state and federal laws prohibiting discrimination in services based on race, age, color, sex, religion, national origin or other protected classification.</p>		<p><u>Place Child's Picture Here</u></p>
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Center:	Child's Name:	Date:
<input type="checkbox"/> Income Verification to Determine Income Eligibility	↔ Choose One	<input type="checkbox"/> Income RE-VERIFICATION (Over Income and 3rd Year Children)

Primary Caregiver Income Information

Type of Income	Amount	How often Income is Received				
Employment	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Yearly
Child Support	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Yearly
SSI	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Yearly
TANF	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Yearly
Unemployment	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Yearly
College Grants & Scholarships	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Yearly
Social Security	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Yearly
Foster Care	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Yearly
Income listed on Family Income Form	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Yearly

Secondary Caregiver Income Information

Type of Income	Amount	How often Income is Received				
Employment	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Yearly
Child Support	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Yearly
SSI	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Yearly
TANF	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Yearly
Unemployment	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Yearly
College Grants & Scholarships	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Yearly
Social Security	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Yearly
Foster Care	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Yearly
Income listed on Family Income Form	\$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Yearly

CALCULATING INCOME

Weekly = Weekly Gross X 52
 Bi-weekly = Bi-weekly Gross X 26
 Monthly = Monthly Gross X 12
 Semi-Monthly = Monthly Gross X 24