

For Office Use Only _____ Head Start Application Date: _____
 Score / Programs eligible for: _____ Early Childhood Education (ECE) _____ Early Head Start Center Base
 _____ Early Learning Initiative (ELI) _____ Early Head Start Home Base

Child's Information

Child's Name: _____ SS#: _____

Date of birth: ____ / ____ / ____ Current Age: _____ Gender: ____ Male ____ Female

Street Address: _____ City / Zip Code: _____

Pick-up & Drop-off address if different from home address: _____

Directions / description: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name & Phone number of message person: _____

Name of Child's Pediatrician: _____ Phone #: _____

Name of Child's Dentist: _____ Phone #: _____

Date and location of child's last well child physical: Dr. _____ date: _____

Does your child have medical insurance? ____ yes ____ no (circle type) Medical Card/Healthy Start - Private Ins.

Child's Race: (circle) White - Black - Bi-racial/Multi-racial - Hispanic - Asian - American Indian - Alaskan

Has your child been previously enrolled in Head Start or another Early Childhood program? ____ yes ____ no

Is your child potty trained? ____ yes ____ no Explain: _____

Is there any other person that has legal custody, guardianship, or visitation rights with this child? _____

If yes, we must be provided with the name and address of such person and copies of any legal/court papers.

Please explain any special concerns you have about your child that you would like for us to know (for example, allergies, health problems, difficult behaviors, no opportunity to socialize with other children, unable to do things that other children the same age can do, etc.)

Income Information - Applications cannot be processed without income information

<u>Check all that applies</u>	<u>Gross Monthly amount received:</u>	<u>Person/s Receiving</u>
_____ Employment	\$ _____	_____
_____ Unemployment	\$ _____	_____
_____ OWF cash assistance	\$ _____	_____
_____ SS	\$ _____	_____
_____ SSI	\$ _____	_____
_____ Child Support	\$ _____	_____
_____ Foster Care Stipend	\$ _____	_____
_____ Other	\$ _____	_____

Family Information - list all family members supported by the income reported on this application

Name	Relationship to Child being enrolled	DOB	SS#	highest grade completed
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Family Type: _____ Foster _____ Single Parent Family _____ Two parent Family _____ Other

Please check services that you are currently receiving:

_____ Food Stamps _____ Medical Card/ Healthy Start _____ WIC
_____ Subsidized child care _____ Public Housing _____ CATS / Transportation
_____ Emergency / Crisis Intervention Program _____ None

List any services that you have applied for that are currently pending: _____.

Do you have adequate housing? ____ yes ____ no

Type of housing: _____ House _____ Apartment _____ Mobile Home/Trailer _____ Hotel
_____ Community Shelter _____ Homeless / living with others

Is there a primary language spoken in your house other than English? ____ yes ____ no If yes, what is it? _____

Would you be able to transport your child to center if we could not provide transportation? ____ yes ____ no

If transportation is not available, would you be interested in the home base option? ____ yes ____ no

Will you need someone to come to your home to complete forms for your child to enroll in our program? _____

How did you hear about our programs? _____

Programs available / requested

Ages 6 weeks - 3 years old.

_____ Early Head Start center base option for parents that are working and/or in school full time and in need of child care on a full time basis.

_____ Early Head Start home base option for infants, toddlers, and pregnant women.

Ages 3 - 4 years old.

_____ Head Start 3.5 hour session / morning & afternoon sessions available.

_____ 7 hour (8:30 am - 3:30 pm) session / preference given to 4 year olds.

_____ Early Learning Initiative or Child Care services for parents that are working and/or in school and in need of child care on a full time basis between the hours of 6 am - 6 pm.

By signing, I certify that the information provided in this application is accurate and truthful to the best of my knowledge. I understand that incorrect information given by me on this form may lead to the dismissal of my child from the program. I hereby agree to limit any and all claims I may have against Community Action Committee of Pike County, Inc. and its staff to the maximum coverage under the agency's liability insurance. I understand that I must provide proof of income before my child can be considered for the program. Please contact the program if you need assistance in determining what type of documents to provide.

Signature of parent or legal guardian: _____

Date: _____

Thank you for requesting an application for the Early Childhood program. Below, I have listed the items that need to be submitted with your application. If you have any questions or need any assistance in obtaining these items, please feel free to contact our office at 740-289-2371 or toll free 1-866-820-1185.

Once we have received your application, we will determine which program your child may be eligible for and put him/her on our waiting list. We will contact you by phone or letter when we get an opening for your child. It is important that you complete all information requested on the application. Failure to do so may result in your child not getting accepted into a program that he/she is eligible for.

Please submit the following with your application:

- Pay stubs for the past 30 days or a copy of your W-2 or 1040 tax form from the past year
- Copy of any legal custody / guardianship papers
- Copy of the enrolling child's medical or insurance card
- Copy of the enrolling child's birth certificate
- Copy of the enrolling child's current shot record. If you cannot find a copy of your child's shot record, please sign the release below giving us permission to request this record from your child's pediatrician. Please return the signed consent with your child's application.

I, _____, give Pike County Community Action permission to obtain a copy of a current shot record, well child physical, and dental exam for my child _____, DOB ____/____/____.

Signature of parent / legal guardian

Date

Signature of Witness

Date