EARLY CHILDHOOD PROGRAM

COMMUNITY ACTION COMMITTEE OF PIKE COUNTY
941 Market Street, Piketon, OH 45661
(740) 289-2371 ▪ Fax (740) 289-1321 ▪ http://www.pikecac.org

Eligibility Application

Please fill in the form completely and accurately. All information will be kept confidential. It will be used to help us determine if your family is eligible for Early Head Start or Head Start services and to prioritize your placement on the waiting list.

If you have any questions about this application, or need any help in completing it, please call us at 740-289-2371 or email us at headstart@pikecac.org. **We will be glad to help!**

Child's Name:_______________________________ Date of Birth:_______________
First, Middle, Last

City and State of Birth: _______________ Mother's Maiden Name: _______________________

Sex: ☐ Male ☐ Female

What language does your child speak most fluently: ☐ English ☐ Spanish ☐ Other ____________

What other language does your child speak: ☐ None ☐ ____________

Race: ☐ White ☐ Black ☐ Bi/Multi Racial ☐ Hispanic ☐ Asian ☐ American Indian ☐ Alaskan

Parent or Guardian Information *(The person signing the application should complete this section.)*

Parent or Guardian's Name:_______________________________________
First, Middle, Last

Date of Birth: _______________ Relationship to Child: _______________
(Example: Mother, Father, Foster Parent, grandparent, etc.)

Home: _______________ Address _______________ City _______________ Zip

Mail (if different): _______________ Address _______________ City _______________ Zip

Telephone: __________ Home __________ Cell __________ Work __________ Message

Highest level of education completed: ☐ Some high school ☐ GED ☐ High School Diploma ☐ Some college ☐ Bachelor degree ☐ Other ____________

Are you currently employed?.. ☐ Yes ☐ No

Are you currently in training or attending school? .... ☐ Yes ☐ No

Other Parent or Guardian Information

Parent or Guardian's Name:_______________________________________
First, Middle, Last

Date of Birth: _______________ Relationship to Child: _______________
(Example: Mother, Father, Foster Parent, grandparent, etc.)

Home: _______________ Address _______________ City _______________ Zip

Mail (if different): _______________ Address _______________ City _______________ Zip

Telephone: __________ Home __________ Cell __________ Work __________ Message

Highest level of education completed: ☐ Some high school ☐ GED ☐ High School Diploma ☐ Some college ☐ Bachelor degree ☐ Other ____________

Are you currently employed?.. ☐ Yes ☐ No

Are you currently in training or attending school? .... ☐ Yes ☐ No

Are you now or have you ever been married to the child's father/mother? ☐ Yes ☐ No

Have any legal documents ever been filed for custody, shared parenting, power of attorney, restraining order, etc. regarding this child? ☐ Yes ☐ No

Family Size and Income

Family Size

In order to determine if your family is at or below the Federal poverty guidelines, we must know how many people are living in your household, as well as your family income. For our purposes, a family is "…all persons living in the same household who are (1) supported by the income of the parent(s) or guardian(s) of the child enrolling in the program, **and** (2) related to the parent(s) or guardian(s) by blood, marriage, or adoption."

Please list all people in the household (including the child being applied for) who are supported by the income listed below. (If you need more room, use another sheet of paper.)

	Name (First, Middle, Last)	**Relationship to Child**	**Date of Birth**	**SS#**	**Highest Grade Completed**
1)					
2)					
3)					
4)					
5)					
6)					

☐ **Single Parent Family** ☐ **Two-Parent Family** ☐ **Foster Parent(s)**

Automatic Eligibility

Is your family receiving TANF benefits? ☐ Yes ☐ No

(TANF benefits include on-going TANF cash grant, PRC, and other TANF-funded benefits and services. Not included are Food Stamps, Medical Card or Emergency Assistance.)

Please provide your Social Security Number: ____________________ or proof that you are currently receiving TANF benefits.

Are you or anyone in your family **currently** receiving Supplemental Security Income (SSI)? ☐ Yes ☐ No

(If you have any questions about the type of Social Security you are receiving, please call the Social Security Office at 1-800-772-1213.)

Is this application for a foster child placed with you through the State of Ohio? ☐ Yes ☐ No

Is your family **currently** Homeless? ☐ Yes ☐ No

(living temporarily in shelters, hotels, or vehicles; or moving frequently between the homes of relatives and friends)

If you answered "Yes" to any of the above, you are automatically income eligible for Head Start services. You may be asked to provide verification(s). Go to the next page.

Family Income

Estimated Annual Gross Income: $________________.00

Income *(see definition below)* must include the total income of all members of the family listed above for either the past twelve months or for the previous calendar year, **whichever more accurately reflects your family's current situation.**

I HAVE ENCLOSED ONE OF THE FOLLOWING REQUIRED DOCUMENTS FOR INCOME VERIFICATION

☐ Pay Stubs (12 months) ☐ Individual Income Tax form 1040

☐ W-2 Forms ☐ Written Statement From Employer / Pay Envelopes

I HAVE ENCLOSED ONE OF THE FOLLOWING ADDITIONAL TYPES OF INCOME VERIFICATION

☐ Unemployment Information ☐ Child Support Information

☐ Social Security Benefits ☐ Financial Aid Award Letter

HEAD START PROGRAM DEFINITION OF INCOME: Income means total cash receipts before taxes from all sources, with certain exceptions. Income includes: (1) money, wages or salary before deductions; (2) net income from non-farm or farm self-employment; (3) social security or railroad retirement; (4) unemployment compensation, strike benefits, workers' compensation, veterans benefits, or public assistance; (5) training stipends; (6) alimony, child support, military family allotments, other regular support from absent family member or someone not living in the household; (7) private pensions, government pensions including military retirement, insurance or annuity payments; (8) college scholarships, grants, fellowships, assistantships; (9) dividends, interest, net rental income, net royalties, receipts from estates or trusts; (10) net gambling or lottery winnings.

Other Assistance

Are you currently receiving assistance from any other agency? *(Please check all that apply)*

☐ Food Stamps ☐ WIC ☐ Subsidized Child Care ☐ CATS/Transportation ☐ Public Housing

☐ Emergency/Crisis Intervention ☐ Energy Assistance (H.E.A.P.) ☐ None

Is your child currently receiving medical or dental coverage through Ohio Medicaid/Healthy Start?............. ☐ Yes ☐ No

Current managed care provider: *(If applicable)* .... ☐ CareSource........... ☐ Molina

Is your child currently receiving medical or dental coverage through private insurance?............................... ☐ Yes ☐ No

Priority

The following information will be used to prioritize your placement on the waiting list. **Please check all that apply.**

DIAGNOSED MEDICAL OR BIOLOGICAL ISSUES

Please indicate any diagnosed medical or biological issues currently affecting your child.

☐ ADHD/ADD

☐ Asthma

☐ Diabetes

☐ Eczema

☐ Hearing impairment

☐ Heart Condition

☐ Seizure disorder

☐ Traumatic brain injury

☐ Visual impairment

☐ Other ____________________________

DIAGNOSED DISABILITIES

Please indicate any disabilities that have been diagnosed for which your child is receiving rehabilitation or special education services. Provide a copy of your child's Individual Family Service Plan (IFSP) or Individual Education Plan (IEP).

☐ Autism

☐ Communication disorder

☐ Developmental delay

☐ Emotional/behavioral disorder

☐ Orthopedic impairment

☐ Other____________________________

FAMILY CIRCUMSTANCES

Please indicate any issues which have occurred to your child's immediate family.

Within the last 12 months

☐ Child abuse or neglect

☐ Death in the family

☐ Divorce

☐ Domestic violence

☐ Drug or alcohol abuse

☐ Incarceration of a parent or guardian

☐ Migrant worker

☐ Homelessness*

Currently

☐ Parent or guardian needs an Interpreter

☐ Parent or guardian receives disability payments

☐ Only one adult lives in the home

☐ Military deployment

☐ Child is in foster care

☐ Child is not in foster care, but is not living with a biological or adoptive parent

☐ Other ____________________________

*(includes families living temporarily in shelters, hotels, or vehicles; or moving frequently between the homes of relatives and friends)

SPECIAL CIRCUMSTANCES

If you would like to be considered for Head Start even though you may not otherwise qualify, please describe the special challenges and circumstances of your family below.

OTHER VOLUNTARY INFORMATION THAT MAY HELP US TO BETTER SERVE YOUR NEEDS:

Does your child have any food, medication, or environmental allergies? .... ☐ Yes ☐ No

Is your child currently using any medication or dietary supplement? .... ☐ Yes ☐ No

Does your child have any dietary restrictions for medical, religious, or cultural reasons?.............................. ☐ Yes ☐ No

Is your child toilet trained? .... ☐ Yes ☐ No

Program Options

Please review the program options below and indicate which would best meet your family's needs.

Full-Day Program / 12 months

Are you applying for Full Day? .... ☐ Yes ☐ No

- Designed for parents who are working, in job training, or attending school and need full-day/year round child care
- Transportation is **not** provided
- Home visits throughout the year
- Typically open Monday – Friday 6:00 a.m. to 6:00 p.m.

Are you working: .... ☐ Yes ☐ No

Are you going to school? .... ☐ Yes ☐ No

Are you in the jobs program? .... ☐ Yes ☐ No

Do you need child care for more than 25 hours per week? .... ☐ Yes ☐ No

Part-Day Program / 9 months

Are you applying for Part Day? .... ☐ Yes ☐ No

- Preschool educational experience combined with socialization
- 3½ hour days, Monday – Thursday, AM or PM
- Limited transportation available

Can you provide transportation for your child to attend? .... ☐ Yes ☐ No

Do you need transportation to other than your home address? .... ☐ Yes ☐ No

The address your child would need picked up at: ______________________________

The address your child would need dropped off at: ______________________________

Home Base Program Option

Are you applying for Home Base?............ ☐ Yes ☐ No

- Provides activities, educational material, encouragement, and support in your home
- Opportunity to attend socializations with other enrolled children twice per month
- Services are provided through 1½ hour weekly home visits

Would you need someone to come to your home to complete enrollment forms?................ ☐ Yes ☐ No

Affirmation

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 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.

______________________________	______________________	______________________
Parent or Guardian Signature	Social Security Number	Date Signed

Community Action Committee of Pike County Early Childhood Program does not discriminate against children or families on the basis on race, color, national origin, gender, religion, age, disability, political beliefs, sexual orientation, and marital or family status.

For Office Use Only

Date Received: _____________ Over Income___ Score ____

Score/Programs Eligible For:

______ Head Start

______ Early Childhood Education (ECE) ______ Early Head Start Center Base

______ Child Care ______ Early Head Start Home Base

Thank you for requesting an application for the Early Childhood Program.
Below, I have listed the items that must be submitted with your application.

* Verification of household income
    - i.e. Pay stubs, W-2 form, 1040 tax form, child support information, social security benefits, unemployment information, written statement from employer
* Copy of legal custody/guardianship papers *(If applicable)*
* Copy of health insurance ID card for child applying *(If applicable)*
    - i.e. Private insurance, Ohio Medicaid/Healthy Start
* Verification of child's age
    - i.e. Copy of birth certificate, hospital documentation, etc.
* Copy of social security card for the child applying
* Copy of immunization record for the child applying
    - If you cannot locate a copy of your child's immunization record, ***please sign the release below*** giving us permission to request this record for you from your child's pediatrician. Please return the signed consent with your child's application.

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 have 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.

Child's current doctor: ______________________________ Phone #:____________________

☐ Child has not yet been seen by a doctor

Child's current dentist: ______________________________ Phone#:____________________

☐ Child has not yet been seen by a dentist

I ______________________________, give the Community Action Committee of Pike
(Legal guardian's printed name)
County permission to obtain a current immunization record, well child physical, and/or dental exam for my child, ______________________________, DOB ____/____/____.
(Child's printed name) (Date of birth)

______________________________ ______________________________
Signature of parent/legal guardian Date

______________________________ ______________________________
Signature of witness Date