

HHWP-CAC Head Start Application

Child's Name _____ Sex: M or F Birthdate _____
(First Middle Last) (Please circle)

Address _____ PO Box _____ City _____ Zip _____

County _____ School District _____ Phone _____

Child's SS# _____ What language does this child speak? _____

If transportation is available, would your child be:

Picked up at home ____ Yes ____ No Dropped off at home ____ Yes ____ No

Do you have legal custody of this child? _____

Are there custody, visitation, or foster care court orders for this child? ____ Yes ____ No (If yes, copy is needed)

Child's Parents are: ____ Married ____ Divorced ____ Separated ____ Widowed ____ Living Together ____ Single Parent

Mother's Name _____ Age _____ S.S.# _____

Home Address _____ Home Phone _____

E-Mail Address _____ Cell Phone _____

Language spoken (if other than English) _____

Employer _____ Phone _____

Can we call you at work? ____ Yes ____ No Is Mom in school or training? ____ Yes ____ No

Work schedule: _____ to _____ School schedule _____ to _____

Check highest completed: ____ some high school ____ HS diploma/GED ____ some college ____ college degree

Father's Name _____ Age _____ S.S.# _____

Home Address _____ Home Phone _____

E-Mail Address _____ Cell Phone _____

Language spoken (if other than English) _____

Employer _____ Phone _____

Can we call you at work? ____ Yes ____ No Is Dad in school or training? ____ Yes ____ No

Work schedule: _____ to _____ School schedule _____ to _____

Check highest completed: ____ some high school ____ HS diploma/GED ____ some college ____ college degree

Step-Parent/Significant Other Name (living with child) _____ Age _____

Cell Phone: _____ E-Mail Address _____

Employer _____ Phone _____

Can we call you at work? ____ Yes ____ No In school or training? ____ Yes ____ No

Work schedule: _____ to _____ School schedule _____ to _____ Language spoken (if other than English) _____

List all people in your home who are not listed above: (Use separate sheet if more space is needed)

Name	Birthdate	Relationship to Child Applying
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are any of the above children also in or applying for Head Start? Who? _____

What is the best time to contact you? _____

Does this child have medical coverage? (check all that apply)

___ Medicaid/Medical Card/Healthy Start ___ Private Medical Insurance ___ Private Dental Insurance ___ None

Name of Insurance: _____

Record of Immunizations: *A copy of the shot record must be attached.*

If you have no copy, where were the shots received? (ie: **which** doctor or health department) _____

How did you hear about Head Start? _____

Has your child ever attended a Head Start Program? Where? _____

If the Head Start Staff is unable to contact you, who could we call who would know how to reach you?

(ie: relative, friend, babysitter, etc.)

Name	Address	Phone	Relationship

*****Family Issues*****

The following information will be used to help us prioritize applications. This information is not required, but could help your child get into the Head Start Program. **Please check any and all that apply.**

Family Issues	Has this been a concern?	If so, when?	Family Issues	Has this been a concern?	If so, when?
Serious family issues			A parent in prison		
Counseling			Child abuse or neglect		
Mental Illness			Domestic violence		
Alcoholism/Drug Abuse			Serious illness in family		
Legal Issues			A parent in the military		
Bankruptcy, Repossession/etc.			Other		
Homeless (or living with family/friends due to no home)					

➔ *If your child has medical concerns or disabilities, please complete the Voluntary Information Page. This information is not required, but could help your child get into Head Start, and possibly receive additional services.*

Voluntary Information Page

It is up to you to give this information or not. If you decide not to, it will not keep your child out of Head Start. If you decide to give it, this information may help us to plan to provide additional services to help your child. Some disabilities/conditions may even help to get your child into Head Start.

*****Disability Information*****

Child's name: _____ **Date of birth:** _____

Do you know or do you suspect that your child has a disability? _____ Yes _____ No


If yes, what is the disability? _____

Is your child receiving help for this disability? _____ Yes _____ No

If yes, what kind of help and who is giving it? _____

Is your child on an IEP? _____ Yes _____ No (If yes, we need a copy)

If yes, **please sign here** if HHWP CAC Head Start may exchange information regarding IEP services with the school district(s) who wrote the IEP and/or the school district in which you currently live?

 **Parent Signature** _____ **Date** _____

*****Child Medical/Development History*****

Was your child full term? _____ Yes _____ No _____ Child's weight at birth

At what age could your child do the following: _____ Sit up _____ Walk _____ Dress self

Check (✓) if your child has ever been diagnosed with any of the following and if she/he is receiving treatment now.

Condition	✓ if child has or had	✓ if currently being treated
Food Allergies		
Allergies		
Vision Problems		
Seizures		
Ear Infections		
Diabetes		
Asthma		

Condition	✓ if child has or had	✓ if currently being treated
HIV/AIDS		
Heart Problems		
Tuberculosis (TB)		
Birth Defects		
Child Abuse		
Counseling		
Other _____		

Share any other information you feel we may need to know about your child:

Complete information below on **all** sources of income **from the past 12 months and/or calendar(tax)year**

Source of Income (Job/wages, Child Support, TANF/OWF, SSI, etc.)	Which person receives this income?	Social Security # of this person	Date income started	Date income ended	Gross Amount (Indicate weekly, monthly, yearly, etc.)
<i>Example: ABC Construction</i>	<i>Joe Sr.</i>	<i>111-22-3333</i>	<i>June 19, 2005</i>	<i>Present</i>	<i>\$420/week</i>

**** Proof of this income is required. Please attach.** If proof of income is not available, please see below.

If you have had very little or no income, please explain how you have obtained food and shelter for the past year: (ie: lived with parents, just divorced, etc.) _____

*******Release of Information*******

_____ Child's Name


Initial the following if permission is granted:

_____ I give permission for HHWP CAC Head Start to exchange information with a contracted childcare provider only as needed to enroll and provide Head Start Services for my child, at the center.

_____ I give permission for HHWP CAC Head Start to exchange information with Department of Job & Family Services programs only as needed to enroll and provide services in DJFS subsidized ELI/Head Start/preschool/childcare services.

_____ I give permission for HHWP CAC Head Start to exchange information with medical/dental providers as needed to follow up on any information provided on the Head Start physical and/or dental, or other Head Start forms regarding medical screenings, vision/hearing, blood pressure, iron/lead levels, allergies, and any special dietary concerns. This information may only be used to provide for my child's health and safety, and may not be used to exclude my child from the program.

I give the HHWP CAC Head Start permission to verify any information contained in this Head Start application. Medical providers, employers, DJFS, Social Security, CSEA, other agencies, and other entities may release information to HHWP CAC Head Start for the purpose of verifying family income, immunization records, health information, date of birth, and custody, for the purpose of enrolling my child in the Head Start program. All information will be kept confidential and HIPPA Rules will be followed. **

 **Parent Signature** _____ **Date** _____

 ***Parent Signature** _____ **Date** _____

*If both parents (or a step-parent whose income is included above) are in the home, please include both signatures.

**This release expires two years from the date of this signature unless revoked in writing by signer.