AREA IV HEAD START

1008 S Fifth St **904 City Park Loop**
Frankfort IN 46041 **Monticello IN 47960**

ENROLLMENT APPLICATION 2010-2011

Please complete this form **completely and accurately**. Incomplete applications will not be processed. All information will be kept confidential. It will be used to help us to determine if your family is eligible for Head Start services and to prioritize your application.

Section I-General Information

Child's Name_____/_____
First Middle Last Nickname

Date of Birth_____ Gender(Sex): M or F
(Please attach Birth Certificate)

Name of Child's Custodial Parent/Parents/Foster parents or Guardian: _____
(Foster parents and guardians should attach documentation)

Home: _____/_____/_____/_____
Address of child's residence City State Zip Code

Telephone_____/_____/_____
Home Work Message/Cell

Mail (if different):_____/_____/_____/_____
Address City State Zip Code

Daycare: _____ Hours attending_____
Name

_____/_____/_____/_____
Address City State Zip Code

_____
Telephone

Please provide the minimum following information with your application:

Child's Birth Certificate
Income-pay check stubs (must have year-to-date figure), SSD stub/deposits, last year's tax forms, etc.
Child Support Documentation, as applicable
Proof of TANF, SSI/SSD, or Foster Care per diem, as applicable
Legal documents (Divorce/Custody/Guardianship/Protective Orders), as applicable
IEP/IFSP, as applicable (child disability info)

Race/Ethnicity (required for a program report)

- ☐ White (non-Hispanic) ☐ Black (non-Hispanic)
- ☐ American Indian ☐ Asian, please specify_____
- ☐ Hispanic/Latino **(if this one is selected, please indicate below your ethnicity by circling all that apply)**

Mexican/Chicano Chilean Puerto Rican
Cuban Guatemalan Central American
Other_____ Other_____

What language is most often spoken at home? _____

Section II-Child Information

Special Needs (adversely affecting learning) ☐ None Suspected

	Suspected	IEP/IFSP Diagnosed	Evaluated by & date:
Speech/Language/Communication Disorder	☐	☐	_____
Severe Visual Impairment	☐	☐	_____
Severe Hearing Impairment	☐	☐	_____
Orthopedic Impairment	☐	☐	_____
Health Impairment	☐	☐	_____
Mental Retardation	☐	☐	_____
Emotional/Behavior Disorder	☐	☐	_____
Learning Disability	☐	☐	_____
Autism	☐	☐	_____
Traumatic Brain Injury	☐	☐	_____
Physical Disability	☐	☐	_____
Developmental Delay	☐	☐	_____
Other Impairment	☐	☐	_____

Handicap accessible Bus needed? [ ] Yes [ ] No
Participated in First Steps [ ] Yes [ ] No
IEP or IFSP complete? [ ] Yes (please attach a copy) [ ] No

How well does the child speak English: Very well Well Not well Not at all

Section III-Family Size and Income

In order to determine if your family income is at or below Federal poverty guideline, we must know how many people are living in your household as well as your family income. For this purpose, 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 the people in the household who meet the above criteria (including the child being applied for).

Name	Relationship to Child	Date of Birth	Education (highest level completed)
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____
4) _____	_____	_____	_____
5) _____	_____	_____	_____
6) _____	_____	_____	_____

Are one or both parents employed or in school?

☐ If Yes, who_____

☐ No

Services or financial assistance received (Mark all that apply):

___TANF
___SSI/SSD (Supplemental Security Income/Social Security Disability)
___Foster Care per diem

___WIC
___Food Stamps
___Unemployment Compensation
___Subsidized Housing
___Energy Assistance Program
___Healthy Families
___Other _____

___Medical financial assistance (i.e. Hoosier Healthwise)
___Child Care Subsidy
___Child Protective Services
___Child Support
___Salvation Army
___Trustee Assistance
___**None of the above**

Environmental issues affecting family members: (Mark all that apply)

___Child Abuse or Neglect
___Homelessness
___Substance Abuse/Mental illness
___Chronic Health Concerns/Disabilities
___Adult Education(ESL/GED, etc.)
___Recent loss of employment
___Child Care
___Other_____

___Basic needs (food, clothing etc.)
___Domestic Violence
___Housing/Utilities
___Parent unable to read
___No transportation
___Incarcerated immediate family member
___Parent in the Military
___Other_____

Which Head Start session do you prefer? (Head Start cannot guarantee placement in any particular classroom or session)

Double Session (3.5 hrs in either AM **or** PM) **--or--** Full Day (parents must either be working 30 hrs/wk or going to school full-time)

If your child does not qualify for Head Start, would you be interested in a Private Pay slot? ____yes ____no

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AREA IV HEAD START DOES NOT DISCRIMINATE AGAINST PEOPLE ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN, GENDER, RELIGION, DISABILITY, AGE, OR MARITAL STATUS.

How did you learn about Head Start?
___Friend/Family
___TANF/Medicaid office
___WIC Office
___Elementary School
___Previous child in program
___First Steps
___Poster/pamphlet/flier
___Newspaper/radio/billboard

Affirmation

Under penalty of perjury, I affirm that I am the parent or legal guardian of the child applying for Head Start, and that, to the best of my knowledge, all of the information that I have provided is complete and correct. In addition, I authorize Head Start to obtain income verification, if needed.

Signature_____ Date _____

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AGENCY USE ONLY

Date Received_____ Family Size_____ Income$ _____/____

Verifications: Birthdate/Age Eligibility_____ Income_____ IEP(when required for non-traditional applicants)_____

Income Eligible_____ - or- Over Income_____

Staff Signature: _____Date_____

Documents reviewed/Comments: _____