

## EARLY HEAD START APPLICATION

Program acceptance is based on the income and needs of family/child, **and not** on a first-come-first-served basis.

<b>Primary Applicant:</b> <i>circle</i>		<b>Pregnant Mother</b>		<b>Child</b>			
<b>Child's Name (Last)</b>		<b>(First)</b>		<b>(MI)</b>	Male <input type="checkbox"/> Female <input type="checkbox"/>	<b>Date of Birth</b> ___/___/___ mo. day year	
Are you currently looking for child care for this child? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, do you need care for you to go to work or school? : _____							
Is child in childcare now? Yes <input type="checkbox"/> No <input type="checkbox"/> What hours is child in care? _____ Do you have child care subsidy from? County <input type="checkbox"/> City <input type="checkbox"/> How much is your weekly co-pay? _____ Type of care? Center <input type="checkbox"/> Family Day Care <input type="checkbox"/> Friend <input type="checkbox"/> Family Member <input type="checkbox"/> Provider Address? _____							
<b>Address (Complete Street Address)</b>			<b>Apt.#</b>	<b>City</b>		<b>Zip Code</b>	
<b>Home Phone #</b> ( ) ( )		<b>Work Phone #</b> ( ) ( )		<b>Pager / Cell #</b> ( ) ( )		<b>Name of Friend/Family and #</b> ( ) ( )	
<b>Birth Mother's Name (Last)</b>			<b>(First)</b>			<b>Date of Birth</b> ___/___/___ mo. day year	
<b>Birth Father's Name (Last)</b>			<b>(First)</b>			<b>Date of Birth</b> ___/___/___ mo. day year	
<b>Guardian or Foster Care Name (Last)</b>			<b>(First)</b>			<b>Date of Birth</b> ___/___/___ mo. day year	
<b>Child's Social Security # not Forward Card</b> - - - - -		<b>Mother's Social Security #</b> - - - - -		<b>Father's Social Security #</b> - - - - -			
<b>Current Living Situation: Rent</b> <input type="checkbox"/> <b>Own</b> <input type="checkbox"/> <b>Living with: family</b> <input type="checkbox"/> <b>friends</b> <input type="checkbox"/> <b>shelter</b> <input type="checkbox"/> <b>of Primary Applicant</b> <b>Other homelessness</b> <input type="checkbox"/> <b>describe:</b> _____							
<b>Marital Status of Parent(s):</b> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married Living Together <input type="checkbox"/> Never Married Not Living Together <input type="checkbox"/>							
<b>Child Lives With:</b> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Foster Care <input type="checkbox"/> Guardian <input type="checkbox"/> Other(Specify): _____							
<b>Is the primary applicant currently pregnant?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Is this your 1<sup>st</sup> pregnancy?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>If yes, trimester of currently in (circle):</b> 1 <sup>st</sup> trimester (0-3 months)      2 <sup>nd</sup> trimester (3-6 months)      3 <sup>rd</sup> trimester (6-9 months) <b>Have you/did you receive prenatal care during this pregnancy?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Regular Prenatal Care?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Which month was your first prenatal visit?</b> 1 2 3 4 5 6 7 8 9 <b>Is/was your pregnancy High Risk (determined by a doctor or health care provider)?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Are you currently seeing a Public Health Nurse or PNCC?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Do you have Medical Coverage / Health Insurance?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>							

**Total # of OTHER people living in your household:** \_\_\_\_\_

1. **Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Sex:** M / F

**Relationship to primary applicant:** \_\_\_\_\_ **Any Income?** Y / N (If so, please specify) \_\_\_\_\_

2. **Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Sex:** M / F

**Relationship to primary applicant:** \_\_\_\_\_ **Any Income?** Y / N (If so, please specify) \_\_\_\_\_

3. **Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Sex:** M / F

**Relationship to primary applicant:** \_\_\_\_\_ **Any Income?** Y / N (If so, please specify) \_\_\_\_\_

4. **Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Sex:** M / F

**Relationship to primary applicant:** \_\_\_\_\_ **Any Income?** Y / N (If so, please specify) \_\_\_\_\_

5. **Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Sex:** M / F

**Relationship to Head Start applicant:** \_\_\_\_\_ **Any Income?** Y / N (If so, please specify) \_\_\_\_\_

**Race of Birth Mother:**  American Indian or Alaska Native  Asian  Black/African American

Native Hawaiian /Pacific Islander  White  Bi-Racial/Multi-Racial  Unspecified Other (specify): \_\_\_\_\_

**Ethnicity:**  Hispanic/Latino  Non-Hispanic/Latino

**Birth Mother's Primary Language:**  English  Spanish  Hmong Other(Specify): \_\_\_\_\_

**Speak English:**  Yes  No  Little

**(Mother)** What is the highest educational grade completed? (Please Circle)

1 2 3 4 5 6 7 8 9 10 11 12 GED HSED 13 14 15 16 Associates BA Grad School No Education

**Race of Birth Father:**  American Indian or Alaska Native  Asian  Black/African American

Native Hawaiian /Pacific Islander  White  Bi-Racial/Multi-Racial  Unspecified Other (specify): \_\_\_\_\_

**Ethnicity:**  Hispanic/Latino  Non-Hispanic/Latino

**Birth Father's Primary Language:**  English  Spanish  Hmong Other(Specify): \_\_\_\_\_

**Speak English:**  Yes  No  Little

**(Father)** What is the highest educational grade completed? (Please Circle)

1 2 3 4 5 6 7 8 9 10 11 12 GED HSED 13 14 15 16 Associates BA Grad School No Education

**Race of Applicant Child:**  American Indian or Alaska Native  Asian  Black/African American

Native Hawaiian /Pacific Islander  White  Bi-Racial/Multi-Racial  Unspecified Other (specify): \_\_\_\_\_

**Ethnicity:**  Hispanic/Latino  Non-Hispanic/Latino

**Child's Primary Language:**  English  Spanish  Hmong Other(Specify): \_\_\_\_\_

**Speak English:**  Yes  No  Little

**Does this child have a diagnosed disability?** Yes  No

Describe the diagnosed disability: \_\_\_\_\_

**Does this child have an Individualized Family Support Plan?** Yes  No

**Is an IFSP underway for this child?** Yes  No

**Does this child receive any special services from a Birth-3 agency or clinic?** Yes  No

Name of program/clinic/provider: \_\_\_\_\_

**Does this child have a suspected disability?** Yes  No

Describe the suspected disability: \_\_\_\_\_

**Does your child receive medical assistance?** Yes  No  **MA/Forward Card #** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Does your child have private health insurance?** Yes  No  **Company:** \_\_\_\_\_

# IMPORTANT!

★ Detailed answers help us determine placement & eligibility.

(If you need more writing space, you may attach a separate piece of paper with your answers and child's name & date of birth written at the top)

Agency  
Use Only

<p><b>1. Why are you interested in Early Head Start and what do you hope to get out of EHS?</b></p>	
<p><b>2. How did you hear about Early Head Start?</b> (Birth to 3, Human Services, Doctor, nurse, WIC, other? Please identify)</p>	
<p><b>3. <i>If primary applicant is pregnant:</i> Are you or did you experience any health problems or complications during this pregnancy, delivery, or after birth?</b> (if yes, please describe)</p>	
<p><b>4. How long did this child stay in the hospital at birth?</b></p>	
<p><b>5. Were there any health concerns or other conditions at this child's birth or in his/her early development?</b> (Please describe)</p>	
<p><b>6. What are your current concerns about your child?</b> (Health, development, speech, taking medication, please describe).</p>	
<p><b>7. Have any major things happened to affect your family or child?</b> (Homelessness, family violence, foster care, neglect, incarceration, death of family member, etc... please describe).</p>	
<p><b>8. Do you have any concerns about providing for your family's basic needs?</b> (Clothing, housing, food, financial, employment, etc..., please describe).</p>	
<p><b>9. Do you, or anyone in your immediate family, have health, dental, nutrition, or mental health concerns?</b> (Please describe)</p> <p><b>Does anyone in your family have a diagnosed or suspected disability, or received educational support in school?</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Who? (describe) _____</p>	
<p><b>10. Are there any other concerns you have for any family members?</b> (Parenting skills, drug or alcohol issue, please specify).</p>	
<p><b>11. Do you receive any of the following services? Check all that apply.</b>          Subsidized Housing <input type="checkbox"/>      Food Stamps <input type="checkbox"/>      WIC <input type="checkbox"/></p>	
<p><b>12. What other services do you/your child receive?</b> (Human Services, Family Preservation, Birth-3, ECI, etc)</p>	

## APPLICATIONS CANNOT BE PROCESSED WITHOUT PROOF OF ALL FAMILY INCOME DURING THE LAST 12 MONTHS

<b>CHECK ALL INCOME THAT IS RECEIVED BY YOUR IMMEDIATE FAMILY</b>	<b>DOCUMENTATION ACCEPTED</b>	
<input type="checkbox"/> Foster Care or Kinship Care <b>for this child</b> Amount Received: \$_____	<ul style="list-style-type: none"> <li>• Foster Care / Kinship Care payment statement or paperwork</li> </ul>	
<input type="checkbox"/> SSI (Supplemental Security income) or Caretaker Supplement Amount Received: \$_____	<ul style="list-style-type: none"> <li>• SSI or Caretaker Supplement statement</li> <li>• Check stub</li> </ul>	
<input type="checkbox"/> W2 Program (NOT including Food Stamps) Amount Received: \$_____	<ul style="list-style-type: none"> <li>• W2 Payment Check Stub</li> <li>• W2 Benefits statement</li> <li>• Child Care Subsidy Documentation</li> </ul>	
<input type="checkbox"/> Child Support Actual Amount Received: \$_____ per <div style="display: inline-block; vertical-align: middle; margin-left: 20px;"> <input type="checkbox"/> Week  <input type="checkbox"/> 2 Weeks  <input type="checkbox"/> Month                     </div>	<ul style="list-style-type: none"> <li>• Child Support payment printouts</li> <li>• Court Documents</li> </ul>	
<div style="display: flex;"> <div style="flex: 1;"> <p>→ <b>Mother Employed?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please list all employers for the past 12 months</p> </div> <div style="flex: 1;"> <p>If <b>No</b>, is mother looking for work?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Employer: _____                      From ___/___/___ to ___/___/___</p> <p>Employer: _____                      From ___/___/___ to ___/___/___</p> </div> <div style="flex: 1;"> <p>Unemploy. Benefit: \$_____ per  <input type="checkbox"/> Week <input type="checkbox"/> 2 Weeks <input type="checkbox"/> Month</p> <p>Income: \$_____ per  <input type="checkbox"/> Week <input type="checkbox"/> 2 Weeks <input type="checkbox"/> Month</p> <p>Income: \$_____ per  <input type="checkbox"/> Week <input type="checkbox"/> 2 Weeks <input type="checkbox"/> Month</p> </div> </div>	<ul style="list-style-type: none"> <li>• Last year's 1040 tax statement</li> <li>• Last year's W-2 employer tax forms</li> <li>• Check stubs</li> <li>• Written statements from employers</li> </ul>	
<div style="display: flex;"> <div style="flex: 1;"> <p>→ <b>Father Employed?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please list all employers for the past 12 months</p> </div> <div style="flex: 1;"> <p>If <b>No</b>, is father looking for work?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Employer: _____                      From ___/___/___ to ___/___/___</p> <p>Employer: _____                      From ___/___/___ to ___/___/___</p> </div> <div style="flex: 1;"> <p>Unemploy. Benefit: \$_____ per  <input type="checkbox"/> Week <input type="checkbox"/> 2 Weeks <input type="checkbox"/> Month</p> <p>Income: \$_____ per  <input type="checkbox"/> Week <input type="checkbox"/> 2 Weeks <input type="checkbox"/> Month</p> <p>Income: \$_____ per  <input type="checkbox"/> Week <input type="checkbox"/> 2 Weeks <input type="checkbox"/> Month</p> </div> </div>	<ul style="list-style-type: none"> <li>• Unemployment Compensation check stub</li> </ul>	
<div style="display: flex;"> <div style="flex: 1;"> <p>→ <b>Guardian Employed?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please list all employers for the past 12 months</p> </div> <div style="flex: 1;"> <p>If <b>No</b>, is guardian looking for work?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Employer: _____                      From ___/___/___ to ___/___/___</p> <p>Employer: _____                      From ___/___/___ to ___/___/___</p> </div> <div style="flex: 1;"> <p>Unemploy. Benefit: \$_____ per  <input type="checkbox"/> Week <input type="checkbox"/> 2 Weeks <input type="checkbox"/> Month</p> <p>Income: \$_____ per  <input type="checkbox"/> Week <input type="checkbox"/> 2 Weeks <input type="checkbox"/> Month</p> <p>Income: \$_____ per  <input type="checkbox"/> Week <input type="checkbox"/> 2 Weeks <input type="checkbox"/> Month</p> </div> </div>		
<input type="checkbox"/> <b>Other income</b> , such as student loans, military income, self-employment, social security payments, disability, etc.	<div style="display: flex;"> <div style="flex: 1;"> <p>Income Type: _____</p> <p>Income Type: _____</p> </div> <div style="flex: 1;"> <p>Income: \$_____ per  <input type="checkbox"/> 2 Weeks <input type="checkbox"/> 2x/Month <input type="checkbox"/> Month  <input type="checkbox"/> Other: _____</p> <p>Income: \$_____ per  <input type="checkbox"/> 2 Weeks <input type="checkbox"/> 2x/Month <input type="checkbox"/> Month  <input type="checkbox"/> Other: _____</p> </div> </div>	<ul style="list-style-type: none"> <li>• Check stubs</li> <li>• Official correspondence (with dollar amounts)</li> </ul>

**Early Head Start and Head Start acceptance is based on the income and needs of the family/child, not on a first-come-first-served basis.**

"I certify that the answers provided on this form are accurate and complete to the best of my knowledge. I understand that providing false information to a Federally Funded Program is against the law. I am this child's parent/guardian and this is our family's income."

**Parent/Guardian Signature (required):** \_\_\_\_\_ **Date:** \_\_\_\_\_

Dane County Parent Council, Inc. is a non-profit corporation. It does not discriminate in the administration of its programs.

**Help keep your information up-to-date by notifying us of any changes at (608) 275-6740.**