

# Head Start Enrollment Application

*Revised 6/02/2009 - Criteria Approved by Policy Council on 3/17/2009*

**Primary Adult** – Complete the following for the parent or guardian living in the home that is the head of the household.

<b>First Name</b>		<b>Last Name</b>		<b>Birth Date</b>	<b>Social Security Number</b>	
<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Ethnicity</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		<b>Primary Language</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____			
	<b>Race – mark all that apply</b> <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Black <input type="checkbox"/> Other: _____		<b>English-speaking Ability</b> <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient			
<b>Are You Disabled?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Relationship to Child Applying for Head Start</b> <input type="checkbox"/> Biological Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Stepparent by Marriage <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> No Legal/Blood Relationship <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other: _____		<b>Medical Insurance Coverage – mark all that apply</b> <input type="checkbox"/> None <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> Nevada Check Up <input type="checkbox"/> Other: _____		
<b>Highest Level of Education</b> <input type="checkbox"/> Grade 9 or Less <input type="checkbox"/> High School Non-Graduate <input type="checkbox"/> High School Diploma/GED <input type="checkbox"/> Some College <input type="checkbox"/> Associate Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree			<b><u>ALL</u> Your Income Sources During the Previous 12 Months – DO NOT leave blank</b> <input type="checkbox"/> Public Assistance (TANF/SSI) <input type="checkbox"/> Pension/Retirement <input type="checkbox"/> Employment/Self-Employment <input type="checkbox"/> School Grants/Scholarships/Fellowships/Assistantships <input type="checkbox"/> Unemployment Compensation <input type="checkbox"/> Foster Care/Adoption Subsidy <input type="checkbox"/> Child Support/Alimony <input type="checkbox"/> Social Security <input type="checkbox"/> No Income Sources <input type="checkbox"/> Other: _____			
<b>Current Employment Status</b> – answer <u>ALL</u> questions below <input type="checkbox"/> Full-Time (35 hours or more weekly) <input type="checkbox"/> Part-Time (Less than 34 hours weekly) <input type="checkbox"/> Seasonally Employed Employer Name: _____ Occupation: _____ Employer Address: _____ Phone Number: _____ <input type="checkbox"/> Training or School <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired or Disabled <b>If you ARE NOT employed, when did you last work?</b> (month & year or N/A if not applicable): _____ <b>Total months worked in the previous 12 months</b> (0 – 12): _____ → From (month/year): _____ To (month/year): _____ <b>How many jobs have you worked at in the previous 12 months?</b> (example: 0 or 2): _____						

**Secondary Adult** – Complete the following for the other parent or guardian living in the home. If not applicable, leave blank.

<b>First Name</b>		<b>Last Name</b>		<b>Birth Date</b>	<b>Social Security Number</b>	
<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Ethnicity</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		<b>Primary Language</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____			
	<b>Race – mark all that apply</b> <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Black <input type="checkbox"/> Other: _____		<b>English-speaking Ability</b> <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient			
<b>Are You Disabled?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Relationship to Child Applying for Head Start</b> <input type="checkbox"/> Biological Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Stepparent by Marriage <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> No Legal/Blood Relationship <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Explain Other: _____		<b>Medical Insurance Coverage – mark all that apply</b> <input type="checkbox"/> None <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> Nevada Check Up <input type="checkbox"/> Other: _____		
<b>Highest Level of Education</b> <input type="checkbox"/> Grade 9 or Less <input type="checkbox"/> High School Non-Graduate <input type="checkbox"/> High School Diploma/GED <input type="checkbox"/> Some College <input type="checkbox"/> Associate Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree			<b><u>ALL</u> Your Income Sources During the Previous 12 Months – DO NOT leave blank</b> <input type="checkbox"/> Public Assistance (TANF/SSI Cash Aid) <input type="checkbox"/> Pension/Retirement <input type="checkbox"/> Employment/Self-Employment <input type="checkbox"/> School Grants/Scholarships/Fellowships/Assistantships <input type="checkbox"/> Unemployment Compensation <input type="checkbox"/> Foster Care/Adoption Subsidy <input type="checkbox"/> Child Support/Alimony <input type="checkbox"/> Social Security <input type="checkbox"/> No Income Sources <input type="checkbox"/> Other: _____			
<b>Current Employment Status</b> – answer <u>ALL</u> questions below <input type="checkbox"/> Full-Time (35 hours or more weekly) <input type="checkbox"/> Part-Time (Less than 34 hours weekly) <input type="checkbox"/> Seasonally Employed Employer Name: _____ Occupation: _____ Employer Address: _____ Phone Number: _____ <input type="checkbox"/> Training or School <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired or Disabled <b>If you ARE NOT employed, when did you last work?</b> (month & year or N/A if not applicable): _____ <b>Total months worked in the previous 12 months</b> (0 – 12): _____ → From (month/year): _____ To (month/year): _____ <b>How many jobs have you worked at in the previous 12 months?</b> (example: 0 or 2): _____						

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## Family's Living and Contact Information

<b>Living Address</b>	<b>Apt/Space #</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
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<b>Mailing Address</b>	<b>Apt/Space #</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
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<b>Primary Phone</b> <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Message  (       )       -	<b>Secondary Phone</b> <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Message  (       )       -	<b>Message Phone</b> <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Message  (       )       -	<b>E-Mail Address</b>
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<b>Current Housing Situation</b> <input type="checkbox"/> Pay Rent <input type="checkbox"/> Do Not Pay Rent <input type="checkbox"/> Own My Home <input type="checkbox"/> Homeless	<b>Dwelling Type</b> <input type="checkbox"/> Apartment (a) <input type="checkbox"/> Single-family House (b) <input type="checkbox"/> Condo/Townhouse (c) <input type="checkbox"/> Duplex/Triplex/4-plex (d) <input type="checkbox"/> Mobile Home/Trailer (e) <input type="checkbox"/> Motel/Hotel (f) <input type="checkbox"/> Shelter (g) <input type="checkbox"/> Park, Street, Car or Campsite (h)	<b>Transportation Situation</b> <input type="checkbox"/> Car (1) <input type="checkbox"/> Car of Friend/Relative (2) <input type="checkbox"/> Public Transportation (3) <input type="checkbox"/> No Transportation (4)
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<b>How Did You Hear About the Head Start Program?</b> <input type="checkbox"/> Phone Book (j) <input type="checkbox"/> Internet Website (j) <input type="checkbox"/> Radio (k) <input type="checkbox"/> Television (l) <input type="checkbox"/> Family (m) <input type="checkbox"/> Friend (n) <input type="checkbox"/> Outside Agency Referral (o) <input type="checkbox"/> Newspaper (p) <input type="checkbox"/> Community Events (q) <input type="checkbox"/> Poster/Flyer (r) <input type="checkbox"/> CSA/HS Internal Referral (t)
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<b>Is the Family Receiving Other Services? – mark all that apply</b> <input type="checkbox"/> WIC <input type="checkbox"/> Food Stamps <input type="checkbox"/> Early Head Start <input type="checkbox"/> Energy Program Assistance <input type="checkbox"/> Section 8 Housing <input type="checkbox"/> HUD Housing Assistance <input type="checkbox"/> No Services
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<b>Family Type – mark all that apply</b> <input type="checkbox"/> Two-parent Family (v) <input type="checkbox"/> Mother Figure Only – Single-parent Family (w) <input type="checkbox"/> Father Figure Only – Single-parent Family (x) <input type="checkbox"/> Grandparent Family (y) <input type="checkbox"/> Foster Family (z) <input type="checkbox"/> Other Relatives (y)
<b>Is Either Parent of the Child Applying for Head Start Incarcerated or Deceased?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Family Size</b> How many adults are living in the home? _____  How many children are living in the home? _____

<b>Please add Any Concerns About Your Child or Family Situation or Any Other Information You Feel We Should be Aware of in Determining Your Child's Enrollment in Head Start and Priority on the Waitlist</b>           
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## Program Applicant Disclosure Statement (Signature Required)

I hereby declare that the information contained in this application for program services is true and correct to the best of my knowledge and understanding. No false or misleading statements have been made by me or anyone representing me. The acceptance of the application does not guarantee that services will be performed under any program, and that services are dependent on many things including accurate applications, availability of funding and determination that the applicant qualifies for the program.

I hereby release, discharge, and exonerate Community Services Agency, their agents and representatives and any person furnishing information or examining information from any and all liability of every nature and kind arising out of the furnishing and inspection of such documents, records and other information, and this release shall be binding on my legal representatives, heirs and assigns. I additionally authorize Community Services Agency and their agents and representatives to use the information that I have provided and aggregated with other customers and clients of Community Services Agency for any and all reporting and funding purposes.

**Applicant's Signature** \_\_\_\_\_ **Today's Date** \_\_\_\_\_

Community Services Agency, its agents, partners and funding sources do not discriminate on the basis of color, sex, age religion, national origin, disability, marital status, sexual orientation or ancestry, or any other consideration made unlawful by applicable discrimination laws. The USDA is an equal opportunity provider and employer.

# Head Start Enrollment Application

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**Applying Head Start Child** – Complete the following for the child you want to enroll in the program.

<b>First Name</b>		<b>Last Name</b>		<b>Birth Date</b>	<b>Social Security Number</b>
<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Ethnicity</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		<b>Primary Language</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		
		<b>Race – mark all that apply</b> <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Black <input type="checkbox"/> Other:		<b>English-speaking Ability</b> <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient	
<b>Relationship to Primary Adult</b> <input type="checkbox"/> Biological Child <input type="checkbox"/> Other Relation – please specify: _____			<b>Relationship to Secondary Adult</b> <input type="checkbox"/> Biological Child <input type="checkbox"/> Other Relation – please specify: _____ <input type="checkbox"/> Not Applicable		
<b>Does your Child Have a Doctor?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Doctor's Name: _____ Address: _____ Phone Number: _____			<b>Does your Child Have a Dentist?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Dentist's Name: _____ Address: _____ Phone Number: _____		
<b>Has Your Child Had a Physical Exam in the Last 12 Months?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? (month & year): _____			<b>Has Your Child Had a Dental Exam in the Last 12 Months?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? (month & year): _____		
<b>Medical Insurance Coverage – mark all that apply</b> <input type="checkbox"/> None <b>Medicaid</b> (select your plan type): <input type="checkbox"/> Anthem Blue Cross/Blue Shield <input type="checkbox"/> Health Plan of Nevada <input type="checkbox"/> Not sure which plan I have <input type="checkbox"/> Nevada Check Up <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Private Insurance → Name: _____ <input type="checkbox"/> Other Coverage → Name: _____ <b>Insurance ID # / Group #</b> _____			<b>Does Your Child Have a Medical Condition That Would Require Medication, Accommodation, or Restriction in the Classroom or During Outside Play? For Example, History of Asthma, Allergies, Seizures, Etc?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Please elaborate on the condition: _____ _____ Is any medication required? <input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____ When was the condition diagnosed? _____ Who diagnosed the condition? _____		
<b>Does your Child Have Special Needs or Disabilities?</b> – please select ONE of the following <input type="checkbox"/> My child DOES NOT have special needs or disabilities and I have no concerns for any <input type="checkbox"/> I am concerned that my child may have special needs or disabilities → Specify: _____ <input type="checkbox"/> My child has diagnosed special needs or disabilities → Specify: _____ <p style="text-align: center;">Does your child have an IEP?: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
<b>Do You Need Full Day Services?</b> – mark all that apply for the Primary Adult and Secondary Adult					
<b>Primary Adult</b> <input type="checkbox"/> Working at least 30 hours per week <input type="checkbox"/> Attending college/university full time <input type="checkbox"/> Working AND attending college/university <input type="checkbox"/> Not working or going to college/university			<b>Secondary Adult (if not applicable leave blank)</b> <input type="checkbox"/> Working at least 30 hours per week <input type="checkbox"/> Attending college/university full time <input type="checkbox"/> Working AND attending college/university <input type="checkbox"/> Not working or going to college/university		
<b>What Kind of Child Care Does Your Child Currently Have?</b> <input type="checkbox"/> None, my child doesn't have any child care <input type="checkbox"/> My child receives care from a relative or babysitter <input type="checkbox"/> My child attends a daycare center					
<b>Preferred Classroom</b> Center Name: _____  <i>* Space in the Full Day and Extended Day sessions is limited</i>			<b>Preferred Session</b> <input type="checkbox"/> Morning (8:00 a.m. – 11:30 a.m., Monday – Thursday) <input type="checkbox"/> Afternoon (1:00 p.m. – 4:30 p.m., Monday – Thursday) <input type="checkbox"/> Extended Day (8:00 a.m. – 1:00 p.m., Monday – Thursday) <input type="checkbox"/> Full Day (7:45 a.m. – 5:15 p.m., Mon – Friday)		
<b>Secondary Classroom</b> Center Name: _____  <i>* Space in the Full Day and Extended Day sessions is limited</i>			<b>Secondary Session</b> <input type="checkbox"/> Morning (8:00 a.m. – 11:30 a.m., Monday – Thursday) <input type="checkbox"/> Afternoon (1:00 p.m. – 4:30 p.m., Monday – Thursday) <input type="checkbox"/> Extended Day (8:00 a.m. – 1:00 p.m., Monday – Thursday) <input type="checkbox"/> Full Day (7:45 a.m. – 5:15 p.m., Mon – Friday)		

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Additional Children Living in the Home – Related to Primary/Secondary Adult by blood, marriage or adoption.					
First Name		Last Name		Birth Date	Social Security Number
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	Race – mark all that apply <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Black <input type="checkbox"/> Other:		Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:	English-speaking Ability <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient
Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to Primary and Secondary Parent Primary Adult      Secondary Adult <input type="checkbox"/> Biological Child <input type="checkbox"/> Biological Child <input type="checkbox"/> Specify Relationship: <input type="checkbox"/> Specify Relationship:			Medical Insurance Coverage – mark all that apply <input type="checkbox"/> None <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> Nevada Check Up <input type="checkbox"/> Other:	
Additional Children Living in the Home – Related to Primary/Secondary Adult by blood, marriage or adoption.					
First Name		Last Name		Birth Date	Social Security Number
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	Race – mark all that apply <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Black <input type="checkbox"/> Other:		Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:	English-speaking Ability <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient
Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to Primary and Secondary Parent Primary Adult      Secondary Adult <input type="checkbox"/> Biological Child <input type="checkbox"/> Biological Child <input type="checkbox"/> Specify Relationship: <input type="checkbox"/> Specify Relationship:			Medical Insurance Coverage – mark all that apply <input type="checkbox"/> None <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> Nevada Check Up <input type="checkbox"/> Other: _____	
Additional Children Living in the Home – Related to Primary/Secondary Adult by blood, marriage or adoption.					
First Name		Last Name		Birth Date	Social Security Number
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	Race – mark all that apply <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Black <input type="checkbox"/> Other:		Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:	English-speaking Ability <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient
Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to Primary and Secondary Parent Primary Adult      Secondary Adult <input type="checkbox"/> Biological Child <input type="checkbox"/> Biological Child <input type="checkbox"/> Specify Relationship: <input type="checkbox"/> Specify Relationship:			Medical Insurance Coverage – mark all that apply <input type="checkbox"/> None <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> Nevada Check Up <input type="checkbox"/> Other: _____	
Additional Children Living in the Home – Related to Primary/Secondary Adult by blood, marriage or adoption.					
First Name		Last Name		Birth Date	Social Security Number
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	Race – mark all that apply <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Black <input type="checkbox"/> Other:		Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:	English-speaking Ability <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient
Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to Primary and Secondary Parent Primary Adult      Secondary Adult <input type="checkbox"/> Biological Child <input type="checkbox"/> Biological Child <input type="checkbox"/> Specify Relationship: <input type="checkbox"/> Specify Relationship:			Medical Insurance Coverage – mark all that apply <input type="checkbox"/> None <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> Nevada Check Up <input type="checkbox"/> Other: _____	