



HEAD START APPLICATION

Application Date _____

Child Information

Child's Legal Name (Last)			(First)	(Middle)		
Preferred Name			Child's Social Security#			
Date of Birth :			Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male			
Race: <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Native American or Alaskan Native <input type="checkbox"/> Other			Language: Primary		Secondary	
			Nationality:			
			Ethnicity:			
Living Address:			Mailing Address:			
City:	State:	Zip:	City:	State:	Zip:	
Primary Phone () - <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Message <input type="checkbox"/> Pager			Secondary Phone () - <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Message <input type="checkbox"/> Pager			
Additional Phone () - <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Message <input type="checkbox"/> Pager			Additional Phone () - <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Message <input type="checkbox"/> Pager			
Email:						
Parental Status: <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Foster <input type="checkbox"/> Non-Parent <input type="checkbox"/> Other			Number in Family:			
Number of Children: Ages: 0 to 3 Ages 4 to 5			Number in Household:			

Family Member Information

Adults						
First and Last Name: (Enter Primary Adult First)	Date of Birth	Social Security #	Gender	Education Level (B1)	Employment Status (B2)	Notes (B3)
(A01)			<input type="checkbox"/> M <input type="checkbox"/> F			
(A02)			<input type="checkbox"/> M <input type="checkbox"/> F			
(A03)			<input type="checkbox"/> M <input type="checkbox"/> F			
(B1) = Last Grade Completed Codes G9 – Up to 9 th Grade GED – Gen Ed. Diploma G10 – 10 th Grade HSG – High School Diploma G11 – 11 th Grade COL – Some College G12 – 12 th Grade CTG – College Degree		(B2) – Employment Status Code F – Full Time U – Unemployed P – Part Time R – Retired S – Seasonal T – Training/School B – Work/Training			(B3) – Notes For Example: Occupation, Training Programs, Etc...	

This application cannot be processed without income verification and birth certificate.

Eligibility Information

ATAP(TANF): <input type="checkbox"/> Yes <input type="checkbox"/> No	Prior ATAP <input type="checkbox"/> Yes <input type="checkbox"/> No	Supplemental Security Income (SSI): <input type="checkbox"/> Yes <input type="checkbox"/> No	WIC: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Income: (List all family members)	Monthly X 12 = Annual Income	Twice a Month X 25 = Annual Income	Weekly X 52 = Annual Income	Every 2 Weeks X 26 = Annual Income	
Family Member	Amount	Per	X	Annual Income	Employer or Income Source
Total Yearly Income of Family					
Was Child Referred to Program <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes by whom) (Why?)					
(Optional) Child has disability or special need: <input type="checkbox"/> No <input type="checkbox"/> Suspected <input type="checkbox"/> Yes (If yes, give diagnosis, date, and source.)					
(Optional) Any specific family needs or crisis? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, describe)					

Child's Name:

Date of Birth:

Family Member Information

Children

First and last name of children in home	Date of Birth	Social Security #	Gender	Related to (D1)	How Related (D2)	Notes (D3)
1 Applicant Child -----						
2			<input type="checkbox"/> M <input type="checkbox"/> F			
3			<input type="checkbox"/> M <input type="checkbox"/> F			
4			<input type="checkbox"/> M <input type="checkbox"/> F			
5			<input type="checkbox"/> M <input type="checkbox"/> F			
6			<input type="checkbox"/> M <input type="checkbox"/> F			
Related to Codes (D1) B12 – Both Adults A01 – Primary Adult A02 – Secondary Adult A03 – Other Adult		How Related Codes (D2) C – Natural Child O – Other G – Grand Child F – Foster Child N – Niece / Nephew		Participation Status Codes (D3) A – Applied Child O – Too old for program N – Eligible Next Year P – Previous Head Start Child Y – Too Young for Program		

Emergency Information

Emergency / Message Contacts

Name:	Address:	Phone: () -
	City: State: Zip:	Phone: () -
Name:	Address:	Phone: () -
	City: State: Zip:	Phone: () -
Name:	Address:	Phone: () -
	City: State: Zip:	Phone: () -

Medical Insurance

Denali KidCare Medicaid Military Native Health Private Other : (Please List)

Doctor

Name: _____ Office: _____ Phone: () -

Dentist

Name: _____ Office: _____ Phone: () -

Certification: I certify that this information is true. If any part is false, my participation in the agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent/Guardian Signature: _____ Date: _____

Eligibility Information – For Agency Use Only

Child Eligible Next Year: <input type="checkbox"/> Yes <input type="checkbox"/> No	Eligibility Priority Criteria		Eligibility Codes and Points	
Sibling Eligible Next Year: <input type="checkbox"/> Yes <input type="checkbox"/> No	Area		Points	Income
Family Income:	Parental Status			Eligible
Income Status: <input type="checkbox"/> Eligible <input type="checkbox"/> Over Income	Disability			25% Below
Income Verification: <input type="checkbox"/> Check Stub <input type="checkbox"/> Tax Return	Income			50% Below
<input type="checkbox"/> Employer Letter <input type="checkbox"/> Other _____	Age			75% Below
Verified By: _____ Date: _____	Other 1			Eligible 101to 130%
Birth Verification: <input type="checkbox"/> Certified Birth Cert.	Total Eligibility Rating			Over Income +130%
<input type="checkbox"/> Hospital Birth Cert. <input type="checkbox"/> Health Dept Cert. <input type="checkbox"/> Other	Eligibility Codes and Points			Other
Verified By: _____ Date: _____	Area		Points	Public Assistance TANF, SSI
Release Signed: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____	Parental Status			Homelessness
Program Information – Staff Use Only	One Parent		30	High Social Service Need
Site:	Two Parent		00	Protective Services Referral
Class:	Foster		100	Referral from other Agency
Program:	Not the Child's Parent		20	Family Crisis
Program Term:	Disability			High Risk Family (Mental H)
Participation Year <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	Zero Disability		00	Serious Health
USDA Status: <input type="checkbox"/> Free <input type="checkbox"/> Reduced <input type="checkbox"/> None	Concern		20	Non English Speaking
	Diagnosed condition		40	Combination
				Not referred / No apparent SS need
				Age on or before August 31st
				4 Years
				3 Years
				3 Years after August 31 st
				Previous HS or EHS
				Head Start Only Transfer from any HS within yr
				HS Only Returning from previous year
				EHS child (Income eligible, currently enrolled)