

<b>Recertification Update</b> Date: _____ Staff Signature: _____
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### Application

Please Print Clearly. If you need assistance completing this application, please tell staff or call the above phone number.

Applicant Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  

Last Name
First Name
MI
Month / Day / Year

Applicant:  Pregnant Woman (EHS)  Transition: PW to EHS  Child 0-3 years (EHS)  Transition: EHS to HS  Child 3-5 years (HS)

Program Preferred: Part Day:  AM  PM  Full Day  Home Base  Combo  Extended Day  Pregnant Woman

Site Preference: 1) \_\_\_\_\_ 2) \_\_\_\_\_

Address: \_\_\_\_\_ City/Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Message/Cell Phone: \_\_\_\_\_ Reside in San Joaquin County?  Yes  No

Mailing address if different: \_\_\_\_\_

How did your family find out about Head Start CDC? \_\_\_\_\_

Are you or a member of your family an employee of Head Start CDC Inc.?  No  Yes \_\_\_\_\_

Name of Employee

<b>Parental Status</b> <input type="checkbox"/> Single Parent <input type="checkbox"/> Two Parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Minor Parent <input type="checkbox"/> Other: _____	
<b>Child Ethnicity</b> <input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic/Non-Latino Origin	Check all that apply <b>Child Race</b> <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Unspecified: _____
<b>Primary Language Spoken in Home:</b> _____ <b>English Speaking Ability:</b> <input type="checkbox"/> Very Well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> None (by Adults) of Parent/Guardian	

*Family means all persons living in the same household who are: 1) supported by the parent or guardian of the child enrolling or participating in the program, and 2) related to the parent or guardian by blood, marriage or adoption.*

ADULTS IN THE FAMILY	BIRTHDATE	GENDER	DUE DATE	EMPLOYMENT/ EDUCATION STATUS	HOW IS ADULT RELATED TO APPLICANT CHILD
Last Name, First Name		Circle		* See Key Below	
Pregnant woman applying for services		N/A			N/A
Head of Household/Primary Adult		M F	N/A		
Other Adult		M F	N/A		

\* **EMPLOYMENT STATUS KEY** F=Full time U=Unemployed P=Part Time R=Retired T=Training/School B=Training/School and Working

CHILDREN IN THE FAMILY	BIRTHDATE	GENDER	HOW RELATED TO APPLICANT	ENGLISH SPEAKING ABILITY	CHILD'S SCHOOL GRADE
Supported by income of parent/guardian		Circle			
Last Name, First Name					
<i>See Above for Applicant Child</i>	N/A	M F	N/A	<input type="checkbox"/> Very Well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> None	N/A
		M F		N/A	
		M F		N/A	
		M F		N/A	
		M F		N/A	

*If additional household members, please attach written list.*

<b>Check all that apply – HS &amp; EHS:</b>	<input type="checkbox"/> TANF/Cal-Works	<input type="checkbox"/> SSI	<input type="checkbox"/> Homeless	<input type="checkbox"/> Foster Child
	<input type="checkbox"/> Active IEP/IFSP	<input type="checkbox"/> EHS to HS Transition	<input type="checkbox"/> EHS Pregnant Woman Program - Transition to Infant Program after Birth	
<b>Check all that apply – Pregnant Women Program only:</b>	<input type="checkbox"/> Chemical Dependency – Prenatal Exposure	<input type="checkbox"/> At risk pregnancy	<input type="checkbox"/> Lack of prenatal care	<input type="checkbox"/> Minor
<b>Family Referred by:</b> <input type="checkbox"/> CPS <input type="checkbox"/> Another Head Start <input type="checkbox"/> Special Ed. Provider <input type="checkbox"/> SELPA/Part C <input type="checkbox"/> Family Child Care Home <input type="checkbox"/> Other: _____				

**PARENTS-PLEASE INITIAL EACH STATEMENT BELOW AND SIGN.**

\_\_\_\_\_ I understand that this is the first step in the application process and does not guarantee my family's enrollment.

\_\_\_\_\_ I understand that I will be contacted by HSCDC staff for additional follow-up and have received information about the next steps in the enrollment process.

**I certify that the above information is true and understand that the submission of false information could disqualify me/my family from the program.**

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Staff Signature \_\_\_\_\_ Date \_\_\_\_\_ Print 1<sup>st</sup> Initial & Last Name \_\_\_\_\_

Approval: \_\_\_\_\_

<b>For Office Use Only</b>	
Data Entry Date: _____	Staff Signature: _____
Print Full Name: _____	

- New Application
- Sibling
- Wait List from Last Program Year
- Recertification with major change
- Other

**Application Status Receipt**

Applicant Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  

Last Name
First Name
MI
Month / Day / Year

Applicant:  Pregnant Woman (EHS)  Transition: PW to EHS  Child 0-3 years (EHS)  Transition: EHS to HS  Child 3-5 years (HS)

Program Preferred: Part Day:  AM  PM  Full Day  Home Base  Combo  Extended Day  Pregnant Woman

Site Preference: 1) \_\_\_\_\_ 2) \_\_\_\_\_

**Documents Reviewed:**

Proof of Age / Legal Name:	<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> Other (Explain)	
Proof of Guardianship: <i>(Attach copy to Application)</i>	<input type="checkbox"/> Foster Care Agreement	<input type="checkbox"/> Court Documents	<input type="checkbox"/> Caregiver's Authorization Affidavit <i>(Medical Rights Only)</i>
Verification for Full Day Program: <i>(Submit copy and attach to Application, prior to 1st day of Attendance)</i>	<input type="checkbox"/> Work Verification with Hours	<input type="checkbox"/> School Schedule or letter from school	<input type="checkbox"/> Training Schedule or letter from training program
Documentation for Risk Factors: <i>(Attach copy to Application)</i>	<input type="checkbox"/> Copy of Active IEP/IFSP	<input type="checkbox"/> Written Referral from: CPS, SELPA/Part C, Special Ed. Provider, Other Head Start, Other:	

**Proof of Income – Check all Documents Reviewed for Each Parent/Guardian**

*Income = Total cash receipts before taxes from all sources for the last twelve (12) months or the last calendar year from all supporting family members related to the applicant by blood, marriage or adoption.*

Name of Parent/Guardian #1:	Name of Parent/Guardian #2:				
Documents Reviewed to Verify Categorical Eligibility: <input type="checkbox"/> TANF Documentation <input type="checkbox"/> Foster Care Reimbursement <input type="checkbox"/> SSI Documentation <input type="checkbox"/> Homeless					
Income Documents Reviewed	# Months	Income of Parent/Guardian #1	# Months	Income of Parent/Guardian #2	Total Income \$
<input type="checkbox"/> Income Tax Form 1040		\$		\$	
<input type="checkbox"/> Unemployment		\$		\$	
<input type="checkbox"/> W-2		\$		\$	
<input type="checkbox"/> Pay Stub or Pay Envelopes		\$		\$	
<input type="checkbox"/> Written Statement from Employer*		\$		\$	
<input type="checkbox"/> Document, signed by parent or guardian, explaining "No Family Income" must be attached.					
Other (Explain)					

*\*Letters from employer must be attached, dated and signed, show total income, number of months person has been employed, and include employer's contact information (letter head preferred).*

Total Number in Family

Total Family Income

**Staff Certification:** I certify that I have reviewed all the above checked documentation and to the best of my knowledge the total family income reflects a full accounting of the family income used to determine eligibility for this applicant and that the applicant is not a relative or friend of mine.

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Staff Full Name: \_\_\_\_\_

Check all that apply – HS & EHS:	<input type="checkbox"/> TANF/Cal-Works	<input type="checkbox"/> SSI	<input type="checkbox"/> Homeless	<input type="checkbox"/> Foster Child
	<input type="checkbox"/> Active IEP/IFSP	<input type="checkbox"/> EHS to HS Transition	<input type="checkbox"/> EHS Pregnant Woman Program - Transition to Infant Program after Birth	
Check all that apply – <i>Pregnant Women Program only:</i>	<input type="checkbox"/> Chemical Dependency – Prenatal Exposure	<input type="checkbox"/> At risk pregnancy	<input type="checkbox"/> Lack of prenatal care	<input type="checkbox"/> Minor
Family Referred by: <input type="checkbox"/> CPS <input type="checkbox"/> Another Head Start <input type="checkbox"/> Special Ed. Provider <input type="checkbox"/> SELPA/Part C <input type="checkbox"/> Family Child Care Home <input type="checkbox"/> Other:				

**Eligibility Status:** Parent or Guardian Initials

	Eligible: Eligible due to family receipt of public assistance (TANF, SSI) or status as foster child or homeless family.
	Eligible: Eligible due to family status - low income (below current year's Federal Poverty Guidelines)
	Pending: <input type="checkbox"/> Family is over income, supporting documentation of active IEP/IFSP attached and submitted to the Multidisciplinary Team. <input type="checkbox"/> Family does not live in San Joaquin County Head Start service area; family needs to request approval letter from other Head Start agency
	Non-eligible: Child is not age eligible, or is over income guidelines (no active IEP/IFSP).
	CEL: Parent/guardian provided information and gives permission to enter application information in <i>Centralized Eligibility List</i>

**I certify that the above information is true and understand that the submission of false information could disqualify me/my family from the program. I also understand that I may appeal enrollment decisions to the HSCDC Delegate Policy Committee.**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_