In order for your child's application to be considered for Head Start, we must have the following items attached to the application…

- ✓ Income Verification (income tax, W-2, child support, income for ***all*** employment in last 12 months)
- ✓ Proof of Birth (birth certificate, hospital record, baptismal record, proof of guardianship-if applicable)
- ✓ Proof of Residency (utility bill – electric, gas) –needs to be in child file
- ✓ Foster forms (if applicable)
- ✓ Medicaid, CHIPS or Private Insurance Verification
- ✓ Immunization Records

Intake Form 1

Eligible Child Demographic Form

SECTION I: BASIC DEMOGRAPHIC DATA

1. Eligible child's name: _____ _____ _____
(First) (Middle) (Last)

2. Nickname: _____ 3. Date of birth: ___/____/___ 4. Gender: ☐ Male ☐ Female

5. Race (check those that apply):

☐ American Indian/Alaskan Native ☐ White ☐ Asian
☐ Black or African American
☐ Native Hawaiian/Other Pacific Islander
☐ Other Specify: _____

6. Ethnicity: _____
☐ Latino or Hispanic ☐ Non-Hispanic

7. Foster Child: Yes_____ No_____

8. Language spoken at home:
Primary: ☐English ☐Spanish ☐Other _____

9. How well does the child speak English?
☐Very Well ☐Well ☐Not Well ☐Not at all

☐Infant/Toddler

SECTION II: ADDRESSES

10. Address (1) Street: _____

City: _____ State: _____ Zip: _____ Effective Date: ____/____/____
(Check all that apply) □Living □Mailing □Pick-up □Drop-off □Other
Home Phone #1: _____ Home Phone # 2: _____

11. Address (2) Street: _____

City: _____ State: _____ Zip: _____ Effective Date: ___/____/_____
(Check all that apply) ☐Living ☐Mailing ☐Pick-up ☐Drop-off ☐Other
Home Phone #1: _____ Home Phone # 2: _____

12. Child previously enrolled in Head Start: ☐yes ☐no
Program _____ Dates _____

SECTION III: RELATIONSHIPS

13.

Other Children in Household	Relationship to Eligible Child	Date of Birth
_____	_____	____/____/_____
_____	_____	____/____/_____
_____	_____	____/____/_____
_____	_____	_ __/____ /____
_____	_____	____/____/_____

SECTION IV: CHILD INFORMATION

14. Child to be cared for by someone other than the head of household in addition to Head Start (check all that apply): ☐Relative ☐Childcare center

☐Older sibling under age 12 ☐Adult non relative in non-relative's home ☐Other: Specify _____

☐Older sibling age 12 or older ☐Adult non relative in child's own home ☐Not yet arranged

Front & Back
Intake Form 2
Family Information

Head of Household for this family: _____ Date of Application: ____/_____/____

1. **Parent type** (check only one):

☐Two Parent family
☐Single Parent family (mother figure only)
☐Single Parent family (father figure only)
☐Single parent family (mother figure only) living w/partner
☐Single parent family (father figure only) living w/partner

Family Type (check only one)

☐ Biological
☐Foster
☐Other family (Please specify:_____)
☐Other relative (Please specify:_____)

2. Parent Status

☐Single parent, not working or student
☐Single parent, working or student
☐Two parents, both working or students
☐Two parents, neither working or students
☐Two parents, one working or student

3. **Type of housing** (check only one):

☐House ☐Mobile home/trailer ☐Hotel/motel room ☐Rent to own
☐Apartment ☐Community shelter ☐Homeless/no housing ☐Other: _____

4. **Housing payment arrangement** (check only one):

☐Exchange services for housing ☐Rent housing ☐Received subsidized housing
☐Make no payment for housing ☐Own housing ☐Other: Specify _____

5. **Length of time at current address**: 6. Number of moves in the past 12 months? _____

☐ less than 6 months ☐ 6-12 months ☐ 1-2 years ☐ more than 2 years

7. **Homeless** in past 12 months (including current homelessness): ☐yes ☐no

7a. Length of time homeless: ☐ Less than 1 month ☐ 1-3 months ☐ 3-6 months ☐More than 6 months

7b. Family acquired housing during enrollment year: ☐ yes ☐ no

Student Residency Questionnaire

Where is the student presently living? (Check One)
___In his/her own house or apartment (Parent or Guardian listed on the lease or mortgage)
___In home of relatives or friends (Parent or Guardian is not listed on the lease or mortgage)
___In a motel, hotel, RV trailer or campground due to lack of other accommodations
___Unsheltered (or moving from place to place)
___In a shelter or transitional living facility

Is the current living situation temporary due to loss of housing or economic hardship? YES or NO
Is the child living with a non-custodial relative due to the incarceration of his/her custodial parent? YES or NO

Front & Back

8. Family currently has *primary* means of transportation: ☐ yes ☐ no

Indicate *primary* means of transportation by checking the box(es) that apply.

☐ Private Vehicle (car, truck, van) ☐ Friend/Relative's vehicle ☐ School Bus

☐ Public Transportation ☐ City Bus ☐ Other ☐ Taxi ☐ Parent Transport

9. Family has *alternate* means of transportation: ☐ yes ☐ no

Indicate *alternate* means of transportation by checking the box(es) that apply.

☐ Private Vehicle (car, truck, van) ☐ Friend/Relative's vehicle ☐ School Bus

☐ Public Transportation ☐ City Bus ☐ Other ☐ Taxi ☐ Parent Transport

Region XIV Head Start program does not own or operate school buses, nor provide transportation. If you would like to request assistance in locating community resources for transportation, please indicate below.

_____ Yes, I would like assistance.

_____ No, I do not need assistance.

10. Family referred from: _____

TYPES OF SERVICES OR FINANCIAL ASSISTANCE CURRENTLY RECEIVING

☐No services received ☐Public Assistance/Welfare (e.g.TANF) ☐SNAP/Food Stamps

☐Child Support/alimony ☐Public Housing Assistance ☐Foster care/adoption

☐Energy program assistance ☐Supplemental Security Income (SSI) ☐WIC

☐EPSDT ☐Unemployment Insurance

☐Medical financial assistance (e.g. Medicaid/Medicare, CHIP)

☐Parent Incarcerated ☐Family in need of assistance ☐Previously Enrolled

☐Migrant/Language ☐Teen Parent ☐Homeless

☐Disability ☐Referral from another agency – documented (not an IEP)

☐Other: Specify _____

Intake Form 3
Family Member Demographics (Mother/Mother Figure)

SECTION I: BASIC DEMOGRAPHIC DATA

1. Person's role in household: □ Household Member □ Resides outside of home

2. Mother/Mother Figure's name: _____ _____ _____
(First) (Middle) (Last)

3. Nickname: _____ 4. Date of birth: ___/___/____ 5. Gender: ☐ Male ☐ Female

6. Race (check those that apply):

☐ American Indian/Alaskan Native ☐ White ☐ Asian
☐Black or African American ☐ Native Hawaiian/Other Pacific Islander
☐ Other Specify: _____

7. Ethnicity: _____
☐ Latino or Hispanic ☐ Non-Hispanic

8. Language spoken at home:
Primary: ☐English ☐Spanish ☐Other _____

9. How well does the mother speak English?
☐Very Well ☐Well ☐Not Well ☐Not at all

10. Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

11. Email address: _____

CELL PHONE: _____ Can we send you text information? _Yes or No___
(Name of Mobile Provider:_____) *Please provide provider name so you can receive text messages.*

SECTION II: RELATIONSHIPS

12. Adults in Household (not guardians)	Relationship to Eligible Child	Date of Birth
_____	_____	____/____/_____
_____	_____	____/____/_____
_____	_____	____/____/_____
_____	_____	____/____/_____

SECTION III: ADULT INFORMATION

13. Applicant currently pregnant? ☐Yes ☐No 14. Due Date: _____

15. Are you currently receiving pre-natal service: ☐Yes ☐No

16. Teen parent questions:

Person is a teen mother	☐Yes	☐No	☐N/A
Attended Parent Program in School	☐Yes	☐No	☐N/A
Enrolled in Teen Parent Program	☐Yes	☐No	☐N/A
Teen Mother Dropped out of School	☐Yes	☐No	☐N/A

Reason:

17. Adult training questions:
Attended Vocational Training, Training or Business School: ☐Yes ☐No ☐N/A
Received certificate or license: ☐Yes ☐No ☐N/A
Participated in Government Training Program: ☐Yes ☐No ☐N/A
Training program(s) attended (check all that apply):
☐JOBS ☐JTPA ☐Job Corps ☐Other: Specify _____
Willing to Pursue Additional Education/Job Training:
☐Yes ☐No ☐N/A

Front & Back

SECTION IV: ADDRESSES (Mother/Mother figure)

18. Address (1) Street: _____

City: _____ State: _____ Zip: _____ Effective Date: _____

(Check all that apply) ☐Living ☐Mailing ☐Pick-up ☐Drop-off ☐Other ☐Same as child

Home Phone #1: _____ Home Phone # 2: _____

SECTION V: EDUCATION

19. Highest level of education completed (check only one): Completion Date: _____/_____/_____

☐No school completed
☐Less than or equal to 4th grade
☐5th-8th grade
☐9th grade
☐10th grade
☐11th grade
☐12th grade (no diploma)
☐High School graduate/GED
☐Some college (but no degree)
☐Associate degree in college
☐Bachelor's degree
☐Master's degree
☐Doctorate degree

SECTION VI: OCCUPATION

20. Person's primary occupational status (check all that apply): Currently employed: ☐ Yes or ☐ No

Paying job:
☐Full-time (more than 34 hrs per week)
☐Part-time
☐Seasonal- Non-agricultural
☐Seasonal- Agricultural
☐Employed and in school

In job training program:
☐Training program with salary
☐Training program without salary

In school: Start Date:_____/_____/___
☐Towards high school diploma/GED
☐Towards trade/business qualification
☐Towards college degree
☐Towards postgraduate degree
☐In school and employed

Unemployed: Date:_____/_____/____
☐With past employment experience
Time since last job: ____ months
☐With no previous employment experience

Other:
☐Homemaker
☐Unable to work due to disability
☐Retired
☐Not applicable

Was parent previously enrolled in Head Start? ☐yes ☐no
If yes, name of program: _____ Year _____

Intake Form 4
Family Member Demographics (Father/Father Figure)

SECTION I: BASIC DEMOGRAPHIC DATA

1. Person's role in household: □ Household Member □ Resides outside of home

2. Father/Father Figure's name: _____ _____ _____
(First) (Middle) (Last)

3. Nickname: _____ 4. Date of birth: ____/___/___ 5. Gender: □ Male □ Female

6. Race (check those that apply):

☐ American Indian/Alaskan Native ☐ White ☐ Asian
☐Black or African American
☐ Native Hawaiian/Other Pacific Islander
☐ Other Specify: _____

7. Ethnicity: _____
☐ Latino or Hispanic ☐ Non-Hispanic

8. Language spoken at home:
Primary: ☐English ☐Spanish ☐Other _____

9. How well does the father speak English?
☐Very Well ☐Well ☐Not Well ☐Not at all

10. Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

11. Email address: _____ _____

CELL PHONE:_____ Can we send you text information?:_Yes or No___
(Name of Mobile provider:_____) *Please provide provider name so you can receive text messages*

SECTION II: RELATIONSHIPS

12. Adults in Household (not guardians)	Relationship to Eligible Child	Date of Birth
_____	_____	____/___/_____
_____	_____	____/___/_____
_____	_____	____/___/_____
_____	_____	____/___/_____

SECTION III: ADULT INFORMATION

13. Teen parent question: Person is a teen father ☐Yes ☐No ☐N/A

14. Adult training questions:
Attended Vocational Training, Training or
Business School: ☐Yes ☐No ☐N/A
Received certificate or license: ☐Yes ☐No ☐N/A
Participated in Government Training Program:
☐Yes ☐No ☐N/A
Training program(s) attended (check all that apply):
☐JOBS ☐JTPA ☐Job Corps ☐Other: Specify
_____
Willing to Pursue Additional Education/Job Training: ☐Yes
☐No ☐N/A

Front & Back

SECTION IV: ADDRESSES (Father/Father figure)

15. Address (1) Street: _____

City: _____ State: _____ Zip: _____ Effective Date: _____

(Check all that apply) ☐Living ☐Mailing ☐Pick-up ☐Drop-off ☐Other ☐Same as child

Home Phone #1: _____ Home Phone # 2: _____

SECTION V: EDUCATION

16. Highest level of education completed (check only one): Completion Date: ____/_____/_____

No school completed
☐Less than or equal to 4th grade
☐5th-8th grade
☐9th grade
☐10th grade
☐11th grade
☐12th grade (no diploma)
☐High School graduate/GED
☐Some college (but no degree)
☐Associate degree in college
☐Bachelor's degree
☐Master's degree
☐Doctorate degree

SECTION VI: OCCUPATION

17. Person's primary occupational status (check all that apply): Currently employed: ☐ Yes or ☐ No

Paying job:
☐Full-time (more than 34 hrs per week)
☐Part-time
☐Seasonal- Non-agricultural
☐Seasonal- Agricultural
☐Employed and in school

In job training program:
☐Training program with salary
☐Training program without salary

In school: Start Date:_____/____/_____
☐Towards high school diploma/GED
☐Towards trade/business qualification
☐Towards college degree
☐Towards postgraduate degree
☐In school and employed

Unemployed: Date:_____/_____/____
☐With past employment experience
Time since last job: ____ months
☐With no previous employment experience

Other:
☐Homemaker
☐Unable to work due to disability
☐Retired
☐Not applicable

Was parent previously enrolled in Head Start? ☐yes ☐no
If yes, name of program: _____ Year _____

Intake Form 5

Certification/Signature Page

PARENT

I certify that information provided is correct to the best of my knowledge and is subject to verification. I am also aware that I may be subject to termination from the program if the information verified disqualifies me from eligibility.

_____ _____

Applicant Signature/Firma del Aplicante: **Print Name of Applicant/Nombre (Use letra imprenta)**

Date/Fecha: _____

Parents Do Not Write Below This Line

STAFF

Eligibility Determination Statement I hereby do certify that the family is eligible to participate in the Early Head Start/Head Start Program. Furthermore, I attest that the application/enrollment packet is complete and I have examined the documents (checked) below and certify that the family is eligible in accordance with Head Start regulations and Eligibility-Recruitment-Selection-Enrollment-Attendance policies.

Documents Reviewed (check all that apply):

☐INDIVIDUAL TAX FORM ☐W-2 ☐ CHILD SUPPORT PAYMENTS

☐PAY STUBS/PAY ENVELOPES ☐UNEMPLOYMENT ☐ SOCIAL SECURITY PAYMENTS

☐WRITTEN EMPLOYER STATEMENTS ☐CURRENT PUBLIC ASSISTANCE RECEIPTS (TANF)

☐WORK HISTORY- VERIFICATION OF EMPLOYMENT ☐ SUPPLEMENTAL SECURITY INCOME

☐WRITTEN VERIFICATION OF VERBAL DECLARATION OF INCOME

☐OTHER: _____

AGENCY SIGNATURES

Interviewed/Assisted By: _____ Date: _____/_____/_____

Staff Eligibility Certification Signature: _____

Certification Date: _____

Print Name of Certifying Staff Member: _____

CHILD ACCEPTANCE DATE: _____/_____/_____ (by Region 14 Head Start)

CHILD ENROLLMENT/ ENTRY/ DATE (first day of service):_____/_____/_____

Intake Form 6
Child Health History

Child's Name_____ **Male**_____ **Female**_____ **DOB**_____ **Age**_____
School_____ **Head Start**_____ **Early Head Start**_____ **Date**_____

* Does your child have Medical Insurance? Yes_____ No_____ Name of Insurance Company:_____
* Does your child have Dental Insurance? Yes_____ No_____ Name of Insurance Company:_____
Reason for no medical / dental insurance? Pending_____ (need proof) Re-Applying_____ (need proof) Denied_____ (need proof) Other___
Child's medical doctor? Name_____ Phone_____ Date of Last Physical: _____
How long has your child been seen at this location? _____ Lead level drawn? Yes_____ No_____ Where? _____
Child's dentist? Name_____ Phone_____ Date of Last Dental Visit: _____
How often does your child visit their dentist? Every 6 months_____ Not Regularly_____ Child has never been to a dentist_____
* Does family receive WIC? Yes____ No____ Do you want information on WIC? Yes____ No____ * Does the family receive SNAP? Yes____ No____
Would anyone in your household benefit from treatment for abuse of Alcohol_____, Drugs_____, and/or Tobacco_____?

Make a Copy of Cards

Check any conditions which your child has:

_____Asthma (Need asthma action plan from doctor)
_____Diabetes (Need diabetes treatment plan from doctor)
_____Blood lead level >5µg/dl (Need result from doctor)
_____Hearing Problems_____
_____Hearing Aids? Left_____ Right_____

(Need allergy action plans for any severe allergies)

_____Allergy to Insects_____
_____Allergy to Food_____
_____Allergy to Medication_____

*** Make a copy of any information provided ***

_____Bleeding Difficulties (Need doctor order for limitations and treatment)
_____Seizures, Convulsions (Need seizure action plan from doctor)
_____Febrile Seizures (Need doctor order for guidance and treatment)
_____Vision Problems_____
_____Wears glasses? Yes_____ No_____
_____Heart condition_____ (Need dr order for limitations)
_____Use assistive devices? Circle: crutches, wheelchair, walker, braces
_____Has EpiPen (Need allergy action plan from the doctor)
_____Other_____

Is your child taking any medications that will need to be administered by the school nurse during school hours? Yes_____ No_____
If yes, what medications? _____

Hospitalizations & Illnesses in the last 6 months . . .	Yes	No	Explain "Yes" Answers (make a copy of physician notes, if needed)
Has your child been hospitalized or operated on?			
Has your child had a serious accident (broken bones, head injuries, falls, burns, poisoning)?			
Has your child had a serious illness?			

DISABILITIES SERVICES: *** Make a copy of any information provided ***

- Do you suspect that your child has a disability or special need? **Yes**_____ **No**_____
- What type of disability does your child have?_____
- Has a professional assessed / diagnosed your child's disability? **Yes**_____ **No**_____
- Has your child received Early Childhood Intervention (ECI) services? **Yes**_____ **No**_____
- Do you have medical documentation or a school district Individual Education Plan (IEP)? **Yes**_____ **No**_____
- Does your child receive disabilities services from a community resource agency? **Yes**_____ **No**_____
  If yes, name of agency and type of service:_____

2020-2021 APPLICATION

Child's Name:_____ **Date**_____

Behavioral / Wellness History	**Yes**	**No**	**If "Yes" is marked please explain**
Does your child have any problems sleeping?			Hours slept per night? _____ Naps per day? _____
Does your child have difficulty with toileting independently?			
Any difficulty with urination?			
Any frequent diarrhea / constipation?			
Does your child wear diapers / pull ups?			
Does your child get any indoor or outdoor physical play?			If yes, minutes per day?
Does your child use electronic devices (video games, computers, phone, and iPad)?			If yes, minutes per day?
Does your child watch TV or movies?			If yes, minutes per day?
Does your child's teacher need any special instructions in caring for your child?			
Does your child have difficulties socializing with other children his/her age?			
Does your child have difficulties separating from parents/other adults?			
Have there been any major changes in your child's life in the last six months?			
Are you or your family having any problems now that might affect your child?			
Is there anything else you want to tell us about your child that will help us understand his/her needs, attitudes, or behavior?			
Pregnancy / Birth History	**Yes**	**No**	**Explain "Yes" Answers (make a copy of physician notes, if needed)**
How far along in pregnancy were you when you went to the doctor?			_____Weeks _____Months _____Never went to the doctor
Were there any complications in pregnancy?			If yes, explain:
Any prenatal exposure to drugs, alcohol, caffeine or tobacco?			If yes, explain:
Any birth defects?			If yes, explain:
Where was your child delivered? Birth weight_____			____Hospital ____Birthing Center ____Home ____Don't know
How long were you and baby in the hospital?			Days for Mother_____ Days for Baby_____ Reason for any extended stay_____
Does the child have any birth problems or concerns that still affect them today?			

Parent/Guardian Name_____ **Phone Number**_____

Parent/Guardian Signature_____

Date Completed_____

Updated February 10, 2020

Intake Form 7
Child Nutritional Assessment

Child's Name_____ **Male**_____ **Female**_____ **DOB**_____ **Age**_____
School_____ **Head Start**_____ **Early Head Start**_____ **Date**_____

Nutritional History / Information	Yes	No	If "Yes" is marked please specify
Does your child have food allergies?			What foods? **PHYSICIAN DOCUMENTATION REQUIRED**
Does your child have food intolerances?			What foods? **PHYSICIAN DOCUMENTATION REQUIRED**
Is your child on a special diet for: ☐ Religious Beliefs **(If yes, parent must provide written instructions on religious dietary practices**) ☐ Medical **(If yes, parent must provide written physician's instructions)**			Explain: **Head Start requires doctor's orders to provide special diet for allergies. All food provided by Head Start. No foods are to be brought in by parents.**
Breastfeeding? ☐ Not applicable			Feedings per day? _____ Minutes per feeding? _____
Bottle feeding? ☐ Not applicable Type of formula? _____			Feedings per day? _____ Ounces per feeding? _____ Brand of bottle used? _____ Type of nipple used? _____
Is child put to bed with a bottle? ☐ Not applicable			If yes, what is in bottle?
Are liquids, beside milk, drank from bottle during the day? ☐ Not applicable			If yes, what?
Does your take a child vitamin/fluoride/mineral supplement?			Contains: ☐ Iron ☐ Fluoride ☐ Prescribed by a doctor
Child drinks water?			☐ Tap water ☐ Bottled water ☐ Well water
Child drinks what during the day with meals/snacks? ☐ Cup ☐ Sippy cup			☐ Milk ☐ Water ☐ Juice ☐ Kool-Aid ☐ Other_____ ☐ Lactose free milk (needs doctor order for school) ☐ Soy milk (needs doctor order for school)
Is your child a picky eater?			
Has your child's appetite changed in the past month?			
Does your child eat or chew things that are not food?			If yes, what?
Do you have any concerns about what your child eats?			
Does your child have trouble with: ☐ Sucking ☐ Chewing ☐ Swallowing ☐ Refusal of any food group What type of difficulty?			
Eating Frequency: Number of meals per day _____ Number of snacks per day _____ Usual daily servings of: Bread/Grains_____ Meat/Beans_____ Milk/Dairy_____ Vegetable_____ Fruits_____ Soda_____ Sweets_____			
Child's favorite foods?			
Child's least favorite foods or disliked foods?			

Parent/Guardian Name _____ Parent/Guardian Signature _____
Date of Completion_____

Consents and Permissions

Child Name: _____ DOB _____Family Name) _____
First MI Last

I hereby give my permission for the following:

Head Start /Early Head Start*:** (Please initial in columns***)

	Yes	No
Vision	_____	_____
Hearing	_____	_____
Heights and Weights	_____	_____
Mental Health Classroom Observation	_____	_____
Social/Emotional Well-Being - Devereux Early Childhood Assessment **(DECA/DECA I/T)**	_____	_____
Developmental Screening (Brigance) *for Head Start/Early Head Start*	_____	_____

Other Permissions/Releases: (***Please initial in columns***)

1) Child to accompany class on Field Trip	_____	_____
2) Release of ***parent*** name and contact information to parent committee officers for use obtaining help in school related projects.	_____	_____
3).Release of ***child name*** & ***photo*** –		
a. Social Media - (Facebook, Twitter, Instagram)	_____	_____
b. Newspaper / TV	_____	_____
c. Region 14 website	_____	_____
d. ESC Publications (Annual Report, Community Assessment, Flyers, Brochures)	_____	_____
e. Educational purposes (teacher trainings to include video taping)	_____	_____
4) Other: Specify _____	_____	_____

Attendance Policy*(important) ***(Please initial in columns)***

1) I will bring my child to school and be on time every day unless they are sick.	_____	_____
2) I understand that excessive absences or tardiness is considered when re-enrolling a child for EHS and HS.	_____	_____
3) I will notify the school if my child is sick or going to be late.	_____	_____

I understand the above consents and permissions.

Parent/Guardian Signature: _____

Print Parent/Guardian Name: _____ **Date** _____/_____/_____

Staff Signature: _____ **Date** _____/_____/_____

Print Staff Name: _____

This form is valid through the current school year