2024-2025

Head Start/Early Head Start Application

Returning Students

Name of Child: _____D.O.B._____

Address of Child: _____Phone: _____

Mother/Mother Figure: _____ D.O.B._____

Address _____ Phone: _____
(if different from child)

Phone Carrier: _____ Email address: _____

(Circle One) Single, Married, Separated, Divorced

Occupation: _____ How long? (Employed/Not Employed)_____

Education Level: _____ When obtained: _____

Father/Father Figure: _____ D.O.B._____

Address _____ Phone: _____
(if different from child)

Phone Carrier: _____ Email address: _____

(Circle One) Single, Married, Separated, Divorced

Occupation: _____ How long? (Employed/Not Employed)_____

Education Level: _____ When obtained: _____

Child's Sibling(s) _____D.O.B._____

_____D.O.B._____

_____D.O.B._____

Type of Housing: (Check One)

____House ____ Mobile Home/Trailer ____Community Shelter

____ Apartment ____ Hotel/Motel room ____Rent to Own

Family acquired housing during enrollment year: _____ Yes _____ No

Homeless/No Housing, Other _____

Length of time at current address: _____ Homeless in past 12 mos. Yes or 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

Transportation: Yes or No (Check One or More)

____ Private vehicle ____ Public Transportation _____ Other

____ Friend / Relative ____ City Bus

Type of Services Received: (Check all that apply) ____ None

____ Medicaid/CHIP ____ Child Support / Alimony ____ Public Housing

____ Food Stamps/SNAP ____ Migrant / Language ____ Foster Care

____ WIC ____ TANF ____ Unemployment

____ Homeless ____ SSI ____ Teen Parent

Disability/Or Any Suspected Disability? Yes or No _____

_____Suspected Disability (Parent Given Resource Information) _____Date: _____

_____Has child ever received any services for developmental delay or disability? _____

If so, When: _____Where: _____

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.

I am aware that I must follow all Head Start Performance Standards including but not limited to Developmental Assessments, Medical exams (Physicals), and Dental exams.

_____ _____

Applicant Signature: **Print Name of Applicant**

Date:_____

_____ _____

Head Start Staff Signature **Date**