

Apple Country Head Start  
Enrollment Application

Poux Senseny DCLC Boyce

Date \_\_\_\_\_ Elementary School Serving Your Neighborhood \_\_\_\_\_

Child Name \_\_\_\_\_  
First MI Last Name

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Gender: M or F

Address \_\_\_\_\_  
Street

Town/City State Zip Code

Mother's Name \_\_\_\_\_ DOB \_\_\_\_\_

Telephone \_\_\_\_\_  
Home Work Cell Phone/ Other Email

Father's Name \_\_\_\_\_ DOB \_\_\_\_\_

Telephone \_\_\_\_\_  
Home Work Cell Phone/ Other Email

Legal Guardian (If applicable) \_\_\_\_\_

Address (If different from above) \_\_\_\_\_

Is the child applying for Head Start a Foster Child? No \_\_\_\_\_ Yes, how long? \_\_\_\_\_

Please check one: **RACE:** \_\_\_ Hispanic or Latino  
or  
\_\_\_ Non- Hispanic or Non-Latino  
**ETHNICITY:** \_\_\_ American Indian or Alaska Native  
\_\_\_ Asian  
\_\_\_ Black or African American  
\_\_\_ Native Hawaiian or Pacific Islander  
\_\_\_ White  
\_\_\_ Biracial/Multi-Racial  
\_\_\_ Other  
\_\_\_ Unspecified- a person whose race is unknown, or decline to identify.

What is the Primary language your child speaks at home? \_\_\_\_\_

Circle one: My child speaks English: Very Well Well Not Well Not at all

Has your child been enrolled previously in any other Head Start or Childhood Development Program?  
No \_\_\_\_\_ Yes, List name \_\_\_\_\_

Has your child been identified or suspected of having a disability?  
No \_\_\_\_\_ Yes, list \_\_\_\_\_

Has any family member been identified or suspected of having a disability?

No \_\_\_\_\_ Yes, list \_\_\_\_\_

**Family Composition**

How many adults are in your family? \_\_\_\_\_ How many children in family? \_\_\_\_\_

Names: \_\_\_\_\_ Age: \_\_\_\_\_ Names: \_\_\_\_\_ Age: \_\_\_\_\_

Is the mother of child pregnant? No\_\_\_ Yes\_\_\_ Is mother/father of child a single parent? No\_\_\_ Yes\_\_\_

Is mother/father of child currently incarcerated? No\_\_\_ Yes, who \_\_\_\_\_

Does family receive services or financial assistance from any of the following programs or agencies?

\_\_\_\_ Medicaid/Medicare \_\_\_\_\_ TANF \_\_\_\_\_ WIC \_\_\_\_\_ Food Stamps

\_\_\_\_ Child Support \_\_\_\_\_ SSI-Supplemental Security Income \_\_\_\_\_ Other: \_\_\_\_\_

What is your family's yearly gross income \_\_\_\_\_

I verify that the information included in this application is true; and if found to be false my child will no longer qualify for this program.

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

**For Office Use ONLY:**

**Family Income**

Family Annual Income: \_\_\_\_\_

Circle One: Under Income Over Income  
Verifications

\_\_\_\_ 1040 \_\_\_\_\_ Unemployment

\_\_\_\_ W2 \_\_\_\_\_ Public Assistance Form

\_\_\_\_ Foster Care Reimbursement \_\_\_\_\_ SSI Documentation

\_\_\_\_ Pay Stubs \_\_\_\_\_ Homeless

\_\_\_\_ Other: \_\_\_\_\_

Documentation of No Income: \_\_\_\_\_

DOB: \_\_\_\_\_

Date

Birth Certificate Number

City/County

State

In accordance with CFR 1305.4 (e), I have determined that this child is income eligible for Apple Country Head Start by reviewing documents stated above.

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