Apple Country Head Start
Enrollment Application

Date_____ Elementary School Serving Your Neighborhood _____

How did you hear about Head Start? _____

Child Name (First)_____(MI) _____ (Last)_____
Date of Birth _____ Gender: M or F

Address (street)_____

(Town)_____(State)_____(Zip)_____

Mother's Name _____ (DOB)_____

High school diploma/GED _____Yes _____No Email_____

Telephone(Home)_____(work)_____(cell)_____

Father's Name_____(DOB)_____

High school diploma/GED _____Yes _____No Email_____

Telephone(Home)_____(work)_____(cell)_____

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Legal Guardian (If applicable) _____ (DOB)_____

Telephone number _____

Address (If different from above) _____

Is the child applying for Head Start as a Foster Child? No_____ Yes, how long? _____

Please check one: **Ethnicity:** ___ Hispanic or Latino

___Non-Hispanic or Non-Latino

Race: ___American Indian or Alaska Native ___White

___Asian ___Biracial/Multi Racial

___Black or African American ___Other

___Native Hawaiian or Pacific Islander ___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 _____

Does your child have any allergies? _____ If so, explain _____

Family Composition

How many adults are in your family? _____ How many children in family? _____
Name: DOB: Name: DOB:
_____
_____
_____

Is the mother of child pregnant? N__ Y __ Is mother/father of child single parent? N __ Y __
Is the mother/father of child currently incarcerated? N __ Y__, who _____

Does family receive services/ financial assistance from any of the following programs/agencies?
___Medicaid/Medicare ___TANF ___WIC ___Food Stamps
___Child Support ___SSI-Supplemental Security Income ___Other: _____

I verify that the formation 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 Over

Verifications

___1040
___W2
___Foster Care Reimbursement
___Pay Stubs
___Documentation of no income
___Unemployment
___Public Assistance Form
___SSI Documentation
___Homeless
___Other: _____

____DOB: _____
Date Birth Certificate # 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_____