EASTERN PLAINS HEAD START PROGRAM APPLICATION FOR ENROLLMENT – Page 1 H-3HS

SITE: Santa Rosa Head Start (Web)
658 S. 5th St.
Santa Rosa NM 88435

Child Applying: _____
First name *Middle name* *Last name*

FAMILY MEMBER INFORMATION– Starting with Primary Adult, complete the following on ALL family members **include the child applying**

	Name		Date of Birth	Social Security Number	Sex		Race							Ethnicity		Language Spoken				English Proficiency				Acquiring/ learning another language in addition to English		Currently Pregnant		Relationship to Child Applying
	First	Last			Male	Female	American Indian or Alaskan Native	Asian	Black or African	Unspecified	Native Hawaiian or Other Pacific Islander	White	Multi-racial/Biracial	Hispanic/Latino	Non Hispanic/Latino	1st English	1st Spanish	2nd English	2nd Spanish	Proficient	Moderate	Little	None	Yes	No	Yes	No	(i.e., mother, father, stepmother, stepfather, brother, sister, grandmother, grandfather, aunt, uncle, other relative, no relation, etc.)
	Joe	Sample	2/02/79	444-22-1234	X						X					X			X	X							X	**Primary Adult - Father**
1																												
2																												
3																												
4																												
5																												
6																												
7																												
8																												
9																												

Education: List the highest level of education for each **ADULT** in the household.

	Name of Adult	Highest Level of Education Completed	Date Completed	Currently Enrolled
	Joe Sample	10th grade	May 25, 1996	Yes (No)
1				Yes No
2				Yes No

Is the child applying related to any teachers at this center? If so, who? (List name/s) _____

FORM ALSO AVAILABLE IN SPANISH

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FAMILY INFORMATION

Living Address: _____
Street
_____
City State Zip Code

Home Phone:_____ Work Phone: _____Message Phone: _____Cell Phone: _____ E- Mail: _____

Home Phone:_____ Work Phone: _____Message Phone: _____Cell Phone: _____ E- Mail: _____

Mailing Address: _____
(If different from home address) Street
_____
City State Zip Code

Parental Status: (Check one)
☐ Two Parents/Guardians ☐ Single Parent/Guardian (mother figure only) ☐ Single Parent/Guardian (father figure only)

Is at least one Parent/Guardian an active duty member of the United States Military? ☐ Yes ☐ No, a veteran of the United States Military? ☐ Yes ☐ No

Employment/Job Training Status: Check all that apply

Two Parents/Guardians are:
☐ employed
☐ in job training or school
☐ not working (unemployed, retired, disabled)

One Parent/Guardian is:
☐ employed
☐ in job training or school
☐ not working (unemployed, retired, disabled)

Types of Service Received *(mark all that apply)*: ☐ No services received
☐ Public Assistance/Welfare (i.e. TANF)* ☐Food Stamps ☐WIC ☐Supplemental Security Income (SSI) ☐Foster Care
☐Health and Wellness Treatment/Therapy ☐Other: Specify _____

***Currently Homeless*:** ☐ Yes ☐ No ☐ Own Housing ☐ Rent Housing ☐ Group Home ☐ Other_____

Type of Housing:
☐ House ☐ Mobile home/trailer ☐ Migrant Housing ☐ Apartment ☐ Community Shelter/Group Home
☐ Hotel/motel room ☐ Other: _____

INCOME INFORMATION:

Number of **Adults** in Family: _____ Number of **Children** in Family: _____ Number of **Adults contributing to the Income**: _____

FAMILY INCOME SOURCES: Check all sources of income.

____WAGES, SALARIES, TIPS
____SUPPLEMENTAL SECURITY INCOME (SSI)
____PENSION.RETIREMENT
____SCHOLARSHIPS/GRANTS
____INTEREST
____UNEMPLOYMENT COMPENSATION
____WELFARE ASSISTANCE (TANF)
____ALIMONY
____TRUSTS, ESTATE RECEIPTS
____ROYALITIES
___WORKER'S COMPENSATION
___VETERAN'S BENEFITS
___CHILD SUPPORT
___NET RENTAL INCOME
___SOCIAL SECURITY BENEFITS
___MILITARY BENEFITS
___FOSTER CARE/ADOPTION SUBSIDY
___DIVIDENDS

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At least 10% of Head Start's enrollment opportunities are made available to children with disabilities; therefore, has this child been identified as having, or is this child suspected to have, any of the following that might require early intervention, special education, and or related services? *(Read list and mark all that apply)* If any items are marked as "Identified" please provide the name of the individual or agency who tested the child and the date of the evaluation.

	Suspected	Identified	Date	Evaluated by:
Autism	☐	☐		
Emotional/Behavioral Disorder	☐	☐		
Health Impairment	☐	☐		
Hearing Impairment including Deafness	☐	☐		
Learning Disability	☐	☐		
Intellectual Disabilities	☐	☐		
Orthopedic Impairment	☐	☐		
Speech or Language Impairment	☐	☐		
Traumatic Brain Injury	☐	☐		
Visual Impairment Including Blindness	☐	☐		
Other Impairments:_____	☐	☐		

If this child is currently receiving services to address any of the needs marked above, please complete this section:

Type of service: _____

Name of person/agency providing the service: _____

Address of Provider_____Telephone_____

OR

_____Child has no known disabilities

IS YOUR CHILD POTTY TRAINED? ☐ Yes ☐ No (This will not affect your child's ability to be enrolled)

This Application cannot be processed unless the following items are attached:

1. Shot Record (must have copy of entire record, including name and Date of Birth);
2. Age Verification - Birth Certificate or Baptismal Certificate;
3. Most Recent Tax Return with all attachments (W-2, schedules, etc.) Federal 1040, 1040A or EZ **AND** NM (PIT) state form.

In Addition, please provide a copy of the most recent physical, lead and iron screening, and dental exam.

SEND COMPLETED APPLICATION TO: Eastern Plains Head Start – P.O. Box 1244 – Tucumcari, NM 88401

I certify that the information provided in this form is accurate and truthful to the best of my knowledge. I give permission for Eastern Plains Head Start to verify any information for the purpose of determining eligibility for participation in the program.

Signature_____ Date: _____

NOTE: Services are provided primarily in classroom setting. Head Start does not provide transportation

EASTERN PLAINS HEAD START PROGRAM
APPLICATION FOR ENROLLMENT

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RELEASE OF INFORMATION

CHILD'S NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

_____

CITY STATE ZIP CODE

Permission is hereby granted by me to the Eastern Plains Head Start Program to secure and/or release any medical/dental or social/educational (including Special Services documents i.e., IEP, IFSP, etc.) information obtained in connection with eligibility for its services, and to make these findings and reports available to those persons or agencies having a valid and legitimate interest in the case of the above named child. Any party so involved will understand that the information thus obtained will be treated as confidential.

I hereby release Eastern Plains Head Start from all legal responsibility or liability that may arise from this authorization.

A photo copy of this release is valid.

Parent/Guardian Signature: _____

Date Signed: _____

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