

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 Street _____
home address) 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 One Parent/Guardian is:
 in job training or school employed
 not working (unemployed, retired, disabled) in job training or school
 not working (unemployed, retired, disabled) 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 _____ UNEMPLOYMENT COMPENSATION _____ SOCIAL SECURITY BENEFITS _____
SUPPLEMENTAL SECURITY INCOME (SSI) _____ WELFARE ASSISTANCE (TANF) _____ VETERAN'S BENEFITS _____ MILITARY BENEFITS _____
PENSION/RETIREMENT _____ ALIMONY _____ CHILD SUPPORT _____ FOSTER CARE/ADOPTION SUBSIDY _____
SCHOLARSHIPS/GRANTS _____ TRUSTS, ESTATE RECEIPTS _____ NET RENTAL INCOME _____ DIVIDENDS _____
INTEREST _____ ROYALTIES _____

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:
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Biological/Medical Risk	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Established Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Environmental Risk	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

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

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

(6 weeks - 35 months)

APPLICATION FOR ENROLLMENT

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: _____