



LANCASTER-FAIRFIELD COMMUNITY ACTION
HEAD START/EARLY HEAD START
Confidential Enrollment Application

\*\* Please submit proof of income with the application to avoid a delay in processing.

I. CHILD INFORMATION:

Child's Name \_\_\_\_\_ Child's Age \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_ Sex: M F
Phone Number \_\_\_\_\_ Child's Social Security No. \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_
Child's Address \_\_\_\_\_ City \_\_\_\_\_
Zip \_\_\_\_\_ County \_\_\_\_\_ School district \_\_\_\_\_

II. FAMILY INFORMATION:

Mother's Name \_\_\_\_\_ Phone Number \_\_\_\_\_
Father's Name \_\_\_\_\_ Phone Number \_\_\_\_\_
Alternate Contact Person \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

PRIMARY EMAIL ADDRESS: \_\_\_\_\_

FOR HEAD START ONLY:

Would you be able to provide daily transportation for your child? (Please circle) [ ] Yes [ ] No
Please check which site you prefer: [ ] Amanda [ ] Sanderson [ ] Tarhe

Number of people living in your house: \_\_\_\_\_ Number in your family: \_\_\_\_\_

List all persons living in your home:

Table with 5 columns: Name, Birth Date, Social Security #, Relationship to Child, Income. Multiple rows for listing family members.

III. INCOME INFORMATION:

Check box only if you have had no income for the past 12 months.
Total Family income before taxes for the past 12 months: \_\_\_\_\_
Do you receive Child Support? [ ] Yes [ ] No
If you are receiving Public Assistance, which type? [ ] OWF [ ] SSI [ ] SNAP \_\_\_\_\_
Are you homeless? [ ] Yes [ ] No Are you a single parent? [ ] Yes [ ] No Are you married? [ ] Yes [ ] No
Is the child in Kinship or Foster Placement? [ ] Yes [ ] No
If yes, who holds custody of the child? \_\_\_\_\_



Return to: Lancaster-Fairfield Community Action Head Start/Early Head Start
1743 E. Main Street, P.O. Box 768, Lancaster, Ohio 43130
Phone: 740-681-4881 or 740-277-4995 Fax: 740-687-1385



**IV. Special Considerations:**

Does your child have a suspected disability?  Yes  No Does your child have a diagnosed disability?  Yes  No

Does your child have a current IEP/IFSP for special services? (Please circle) Yes No

Do you have any concerns about your child's development (walking, talking, playing, crawling, sitting)?

Yes No Please Explain: \_\_\_\_\_

Does your child have any health needs, allergies, or medical conditions? Yes No

Please explain \_\_\_\_\_

Is your child receiving services from any other agencies or enrolled in any other educational programs? Yes No

What agencies or programs? \_\_\_\_\_

Is your child enrolled in Help Me Grow? Yes No Service Coordinator \_\_\_\_\_

Has this child been in Head Start/Early Head Start before? Yes No If yes, where? \_\_\_\_\_

What is your family's preferred language? English \_\_\_\_\_ Other \_\_\_\_\_

What is the child's primary language? English \_\_\_\_\_ Other \_\_\_\_\_

Which language does your child use most to communicate with you, family, and friends? \_\_\_\_\_

**By checking this box, you are allowing us to share your information with our partner, Lancaster City Schools. We work collaboratively to provide services to children in Fairfield County.**

**ALL PERSONS MAKING APPLICATION TO HEAD START/EARLY HEAD START MUST ATTACH VERIFICATION OF ALL FAMILY ANNUAL INCOME FOR THIS APPLICATION TO BE CONSIDERED.**

I attest that the income and other preceding information is true to the best of my knowledge and I authorize the release of any or all information necessary for verification purposes. I further understand that intentionally providing misleading, inaccurate or untruthful information could result in serious legal consequences to me and loss of Head Start/Early Head Start services for my child.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**How did you first hear about Head Start/Early Head Start?**

\_\_\_\_\_ Flyer or Poster \_\_\_\_\_ A person came to my home \_\_\_\_\_ Community Action Agency

\_\_\_\_\_ Friend or Relative \_\_\_\_\_ Social Media \_\_\_\_\_ Public Schools

Referred by: \_\_\_\_\_ Other \_\_\_\_\_

**For Office Use Only**

Age \_\_\_\_\_ EHS \_\_\_\_\_ HS Center \_\_\_\_\_ Returning Child \_\_\_\_\_ HMG \_\_\_\_\_

Public Assistance: TANF/OWF \_\_\_\_\_ SSI \_\_\_\_\_ SNAP \_\_\_\_\_ Income Eligible \_\_\_\_\_ Over Income \_\_\_\_\_

Categorically Eligible: Foster \_\_\_\_\_ Homeless \_\_\_\_\_ Wait List Date \_\_\_\_\_ Acceptance Date \_\_\_\_\_

Screened by \_\_\_\_\_ Date \_\_\_\_\_

- Check Stubs (past 12 months)
- Worker's Compensation (past 12 months)
- Social Security Statement
- Verification of Child Support (past 12 months)
- Self Declaration of Income Form
- OWF/TANF/SNAP Award Letter (current)
- Income Tax Statement
- Other Income Statement (past 12 months)
- Unemployment Statement (12 months)
- W-2 Form
- SSI
- Foster
- Homeless