



**2010 - 2011  
CAP Agency Head Start/Early Head Start  
Application**



Serving Scott, Carver and Dakota Counties  
**RETURN TO:** 2496 145th St W, Rosemount, MN 55068  
Telephone: 651-322-3500/Fax: 651-322-3555

**\*\*\*This is only an application and does not mean your child is enrolled\*\*\***

Please print all information clearly and complete information for all family members.

**Program** (check one):  Head Start – Ages 3-5 yrs. (must be 3 by September 1<sup>st</sup>)  
 Early Head Start (home visit program) – Ages prenatal to 3 yrs.

**Preferred Location/s:**  Rosemount       Westview-Apple Valley       Northview-Eagan  
 Hamilton-Savage       Family/Kid Connections-S St Paul

**Number of individuals in the household** \_\_\_\_\_

**Information for Head of Household (HOH) Member 01:**

_____			_____			_____		
Parent/Guardian First Name			Middle Name			Last Name		
_____				_____		_____		_____
Street Address				City		County		Zip Code
_____			_____			_____		
Primary Phone – Cel/Home/Wk			Secondary Phone – Cel/Home/Wk			Other Phone – Cel/Home/Wk		
Email Address: _____								
Date of Birth:			Gender: MALE FEMALE			Disabled YES NO		
Marital Status:			Veteran YES NO			Education Level:		
Hispanic		YES	NO	Type of Medical Insurance:				
Do you speak English?		YES	NO	1 <sup>st</sup> Language Spoken:				
<b>Race (Choose as many as apply)</b>								
<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Am Indian/Alaska Native <input type="checkbox"/> African-American <input type="checkbox"/> African <input type="checkbox"/> Other								

**Housing Situation:**

Home that I own, rent or share by choice

Temporarily living with a family member or friend due to loss of housing, economic hardship or similar reason

Subsidized (Section 8, HUD, Rent Assistance)

At Risk of Homelessness

Homeless

Staying in emergency or transitional shelter/housing

Living in a motel/campground/vehicle because I cannot afford or find affordable housing

Moved more than 3 times in 12 months

Other

**Family Type:**

- Two Parent Household   
  Single Parent Female   
  Single Parent Male   
  Grandparent(s) and Children  
 Foster Parent(s)   
  Single Person   
  Non-Custodial Caregiver(s)   
  Other

**LIST ALL FAMILY MEMBERS LIVING IN THE HEAD START CHILD'S HOUSE. INCLUDE THE HEAD START CHILD.**

#	Relationship to Head of Household	Name:		Sex	Date of Birth	Disability: Yes or No	Education Level	Insurance	Type of Medical	Race
		First	Last							
02	Head Start Child									
03										
04										
05										
06										
07										
08										
09										
10										

How many parents are employed     None     One     Two

How many parents are in school/training     None     One     Two

Household type     One Parent     Two Parents

**IMPORTANT**

**Head Start needs to verify TOTAL family income before taxes.**

**NON-CASH BENEFITS – PLEASE CHECK ALL THAT YOU RECEIVE**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Food Support/EBT                  | <input type="checkbox"/> WIC                             | Are you a registered Voter?                              |
| <input type="checkbox"/> MEDICAID/MA                       | <input type="checkbox"/> Section 8 or Rent Assistance    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> MEDICARE                          | <input type="checkbox"/> Earned Income Tax Credit (EITC) |  |
| <input type="checkbox"/> State Children's Health Insurance | <input type="checkbox"/> Childcare Assistance            |  |
| <input type="checkbox"/> VA Medical Services               | <input type="checkbox"/> Energy Assistance               |  |
| <input type="checkbox"/> Other _____                       | <input type="checkbox"/> MN Care                         |  |

**Income verification .... (Continued)**

Total Gross Annual family income must be verified before your application can be processed. Please include the following verification with your application:

\* A copy of your tax return or W-2 (income for the last calendar year).

**-OR-**

\* Copies of your check stubs and proof of other sources of income from the list below (income for past 3 months).

**SOURCES OF CURRENT INCOME – PLEASE CHECK ALL THAT YOU RECEIVE**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Salary or Wages | <input type="checkbox"/> MSA             | <input type="checkbox"/> Retirement, Pension | <input type="checkbox"/> Child Support/Alimony |
| <input type="checkbox"/> Unemployment    | <input type="checkbox"/> Social Security | <input type="checkbox"/> SSI                 | <input type="checkbox"/> MFIP/TANF/DWP         |
| <input type="checkbox"/> Interest/Other  | <input type="checkbox"/> Self Employment | <input type="checkbox"/> No Income           |  |

**Has your family received any of these in the past 12 months?**

- |                                 |          |
|---------------------------------|----------|
| TANF/MFIP/DWP (cash support)    | Yes / No |
| MFIP Food Stamps (food support) | Yes / No |
| Transitional Year Child Care    | Yes / No |
| Foster Care Grant               | Yes / No |
| SSI                             | Yes / No |
| GA                              | Yes / No |

\*\*Families who have received TANF/MFIP/DWP, SSI, Foster Grant or General Assistance for at least 2 consecutive months in the past 12 months are income eligible for Head Start\*\*

**OFFICE USE ONLY**

Eligibility Information:

Income Verified by: \_\_\_\_\_  
Staff Signature Staff Signature

Eligibility: E \_\_\_\_\_ OI \_\_\_\_\_ Homeless \_\_\_\_\_ Public Assistance \_\_\_\_\_ Foster Care \_\_\_\_\_ SSI \_\_\_\_\_

Enrollment Information: PLUS \_\_\_\_\_ Special Needs \_\_\_\_\_ Repeat Family \_\_\_\_\_

(1<sup>st</sup> Year) Initials of Enrollment Committee \_\_\_\_\_ Date: \_\_\_\_\_

Acceptance Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Start Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ FSC \_\_\_\_\_ Class \_\_\_\_\_

Repeat Child \_\_\_\_\_

(2<sup>nd</sup> Year) Initials of Enrollment Committee \_\_\_\_\_ Date: \_\_\_\_\_

Acceptance Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Start Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ FSC \_\_\_\_\_ Class \_\_\_\_\_

**Reminder: This is only an application and does not mean your child is enrolled.**

**\*\*\*You must complete a copy of this page for each child that you wish to enroll\*\*\***

**Legal Name of Child you wish to enroll:**

\_\_\_\_\_ **First** \_\_\_\_\_ **Middle** \_\_\_\_\_ **Last**

Does your child go by any other name? Yes /No Please List: \_\_\_\_\_

**Child's Birth Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Male / Female (circle one)  
Month Day Year

Has your child ever been diagnosed by a Doctor for any of the following conditions?

- Allergic Reaction
- Food Allergy
- Asthma or other upper respiratory breathing issues

Specify Allergies/Condition: \_\_\_\_\_

Specify medications child is currently taking: \_\_\_\_\_

\*Does your child have a special need? Yes / No Explain \_\_\_\_\_

\*Head Start accepts children with special needs and/or medical conditions

Has your family been in Head Start before? Yes / No If yes, when? \_\_\_\_\_ If yes, which county? \_\_\_\_\_

I have read and fully understand the above. I agree that all answers given are true and complete to the best of my knowledge. I also understand that if any of the information changes or is incorrect, I will contact Head Start. All information will remain confidential.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*(Signature and Date Required)*

**Return application to: CAP Agency, 2496 145<sup>th</sup> St W, Rosemount, MN 55068**

If you need help completing this application:  
Scott and Carver County residents call 952-496-2125  
Dakota County residents call 651-322-3500  
*Hearing impaired use MN Relay Service 1-800-627-3529*