

Referral



2017 - 2018

Early Head Start/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

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 Sept 1st)

[ ] Early Head Start - Ages prenatal to 3 years old (home visit program)

\*\*\*Parent/guardian must provide transportation\*\*\*

Preferred Location/s: [ ] Rosemount [ ] Apple Valley [ ] Savage
[ ] S.St.Paul [ ] Eagan [ ] Chaska
[ ] Inver Grove Heights [ ] Shakopee

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

Parent/Guardian Information for Family Member 01: Head of Household (HOH)

Form fields for Parent/Legal Guardian information including First Name, Middle Name, Last Name, Street Address, City, County, Zip Code, and contact information (Cell, Home, Work, Email).

Form fields for demographic and employment information including Date of Birth, Gender, Disabled status, Hispanic status, Education Level, Employment status, English proficiency, Language spoken, Legal guardian status, Race, and U.S. Military Member status.

Housing Situation - Please check all that apply:

- A. [ ] Home that I rent, own or share by choice
B. [ ] Temporarily living with a family member or friend due to loss of housing, economic hardship or similar reason
C. [ ] Subsidized (Section 8, HUD, Rent Assistance)
D. [ ] At Risk of Homelessness
E. [ ] Homeless
F. [ ] Staying in emergency or transitional shelter/housing
G. [ ] Living in a motel/campground/vehicle because I cannot afford or find affordable housing
H. [ ] Other: \_\_\_\_\_

**Family Information:** One Parent Household Two Parent Household Foster Parent(s)\*

(\*\* If a Foster Parent, a copy of the court/legal doc must be included for eligibility verification)

**LIST ALL FAMILY MEMBERS LIVING IN THE HEAD START CHILD'S HOUSE. INCLUDE THE HEAD START CHILD.****2<sup>nd</sup> Parent/Guardian Member 02**

<b>First Name:</b>	<b>Last Name:</b>	<b>U S Military Member:</b>	<b>Yes / No</b>	
<b>Relationship to HOH:</b>	<b>Gender (circle one):</b> Male      Female	<b>Date of Birth:</b>	<b>Disability (circle one):</b> Yes      No	<b>Race:</b>
<b>Education Level:</b>	<b>Employed: Yes / No</b> Full or Part Time?	<b>Parent In School or Training: Yes / No</b> Full or Part Time? (circle applicable answers)		

**Family Member 03**

<b>First Name:</b>	<b>Middle:</b>	<b>Last:</b>		
<b>Relationship to HOH:</b>	<b>Gender (circle one):</b> Male      Female	<b>Date of Birth:</b>	<b>Disability (circle one):</b> Yes      No	
<b>Education Level:</b>	<b>Race:</b>			

**Family Member 04**

<b>First Name:</b>	<b>Middle:</b>	<b>Last:</b>		
<b>Relationship to HOH:</b>	<b>Gender (circle one):</b> Male      Female	<b>Date of Birth:</b>	<b>Disability (circle one):</b> Yes      No	
<b>Education Level:</b>	<b>Race:</b>			

**Family Member 05**

<b>First Name:</b>	<b>Middle:</b>	<b>Last:</b>		
<b>Relationship to HOH:</b>	<b>Gender (circle one):</b> Male      Female	<b>Date of Birth:</b>	<b>Disability (circle one):</b> Yes      No	
<b>Education Level:</b>	<b>Race:</b>			

**Family Member 06**

<b>First Name:</b>	<b>Middle:</b>	<b>Last:</b>		
<b>Relationship to HOH:</b>	<b>Gender (circle one):</b> Male      Female	<b>Date of Birth:</b>	<b>Disability (circle one):</b> Yes      No	
<b>Education Level:</b>	<b>Race:</b>			

\*Attach another sheet for additional family members.

# 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"/> Earned Income Tax Credit (EITC)	<input type="checkbox"/> WIC
Are you a registered Voter?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	

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

- \* A copy of your federal 1040 tax return or W-2 (income for the last calendar year).      **-OR-**  
 \* Copies of your check stubs & proof of other sources of income from the list below (income for previous 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 |
| Foster Care Grant               | Yes / No |
| SSI                             | Yes / No |

**\*\*Families who have received TANF/MFIP/DWP, SSI or Foster Care Grant for at least 2 consecutive months in the past 12 months are income eligible for Head Start\*\* Please include copies of this with your application.\*\***

### OFFICE USE ONLY

Eligibility Information:	
Income Verified by: _____	_____
Staff Signature	Staff Signature
Eligibility: E _____ OI _____ Homeless _____ Public Assistance _____ Foster Care _____ Transfer _____ SSI _____	
Enrollment Information: PLUS _____ Special Needs _____ Repeat Family _____	
(1 <sup>st</sup> Year) Initials of Enrollment Committee _____	Date: _____
Acceptance Date: _____ / _____ / _____	Start Date _____ / _____ / _____ FSC _____ Class _____

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

**Legal name of child or prenatal mom you wish to enroll:**

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

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

**Child's Birth/Due Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Male / Female (circle one)

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/Medical Conditions: \_\_\_\_\_

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

\*Does your child have a special need (IFSP or IEP)? 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 agree to contact Head Start if any of the information changes or is not current, as failure to do so could delay my child's enrollment.** All information will remain confidential.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
*(Signature and Date Required)*

**\*\*Head Start staff will conduct an in-person or phone interview with each family\*\***

**\*\*Head Start program requires that we verify date of birth, so please provide a copy of your child's birth certificate\*\***

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

If you need help completing this application:  
Please call 651-322-3500.

*Hearing impaired use MN Relay Service 1-800-627-3529.*

