

Referral



2019 - 2020

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
Email: headstart@capagency.org

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
[] W. St. Paul [] Eagan [] Chaska
[] Inver Grove Heights [] Shakopee

Number of individuals in the household _____

Is anyone in the household pregnant? Yes / No

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

Form fields for Parent/Legal Guardian information including Name, Address, City, County, Zip Code, and Contact Information.

Table with demographic and background information including Date of Birth, Gender, Education Level, Employment, Language Spoken, and Race.

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, CDA, 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)** County: _____
(* ** 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.

2nd Parent/Guardian/Member 02

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

Family Member 03

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

Family Member 04

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

Family Member 05

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

Family Member 06

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

*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? Yes No		

<p>Total Gross Annual family income must be verified before your application can be processed. Please include the following with your application:</p> <p style="padding-left: 20px;">* 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).</p> <p>SOURCES OF CURRENT INCOME – PLEASE CHECK ALL THAT YOU RECEIVE</p> <table style="width: 100%;"><tr><td><input type="checkbox"/> Salary or Wages</td><td><input type="checkbox"/> MSA</td><td><input type="checkbox"/> Retirement, Pension</td><td><input type="checkbox"/> Child Support</td></tr><tr><td><input type="checkbox"/> Unemployment</td><td><input type="checkbox"/> Social Security</td><td><input type="checkbox"/> SSI</td><td><input type="checkbox"/> Alimony</td></tr><tr><td><input type="checkbox"/> Self-Employment</td><td><input type="checkbox"/> No Income</td><td><input type="checkbox"/> MFIP/TANF/DWP</td><td><input type="checkbox"/> Other:</td></tr></table>	<input type="checkbox"/> Salary or Wages	<input type="checkbox"/> MSA	<input type="checkbox"/> Retirement, Pension	<input type="checkbox"/> Child Support	<input type="checkbox"/> Unemployment	<input type="checkbox"/> Social Security	<input type="checkbox"/> SSI	<input type="checkbox"/> Alimony	<input type="checkbox"/> Self-Employment	<input type="checkbox"/> No Income	<input type="checkbox"/> MFIP/TANF/DWP	<input type="checkbox"/> Other:
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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 _____ EHS _____

(1st Year) Initials of Enrollment Committee _____ Date: _____

Acceptance Date: _____ Start Date _____ FSC/FE _____ Class _____

(2nd Yr) Acceptance Date: _____ Start Date _____ FSC/FE _____ Class _____

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

Legal name of child or pregnant mother to be enrolled:

_____ **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: _____

*Has your child been identified as having a disability? Yes / No Which school district and what is the disability? _

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

Do you have concerns about your child's development or behavior? Yes / No Explain _____

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

Has your child had an Early Childhood Screening in MN? Yes / No Which school district? _____

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****

****Please provide a copy of your child's birth certificate****

How did you hear about us? Friend/Neighbor Flyer Social Services School District Other: _____

Return application, birth certificate, and all income documents to:
CAP Agency, 2496 145th 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.

