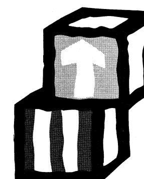
☐ Referral

2020-2021
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   If yes, what is the Due Date:____________________

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

____________________ ____________ ____________________
Parent/Legal Guardian First Name   Middle Name   Last Name

____________________ ____________ ________ ________
Street Address   City   County   Zip Code

____________________ ____________________ ____________________
☐Cell ☐Home ☐Work ☐Text   ☐Cell ☐Home ☐Work ☐Text   ☐Cell ☐Home ☐Work ☐Text

Email Address: ____

Date of Birth:	Gender: MALE FEMALE	Disabled: YES NO
Hispanic: YES NO	Education Level:	Employed: YES NO - Full or Part Time?
Do you speak English? YES NO Interpreter needed? YES NO	1st Language Spoken:	Parent In School or Training: YES NO Full or Part Time? (circle applicable answers)
Are you the legal guardian of the Head Start Child: YES NO		
Race (Choose as many as apply)		U S Military Member: YES NO Veteran: YES NO

☐White ☐Asian ☐Native Hawaiian/Pacific Islander ☐Am Indian/Alaska Native ☐Black or African-American ☐Other

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 **Race:**
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

☐ Food Support/EBT ☐ Earned Income Tax Credit (EITC) ☐ WIC

Are you a registered Voter? Yes 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

☐ Salary or Wages	☐ MSA	☐ Retirement, Pension	☐ Child Support
☐ Unemployment	☐ Social Security	☐ SSI	☐ Alimony
☐ Self-Employment	☐ No Income	☐ MFIP/TANF/DWP	☐ Other:

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

TANF/MFIP/DWP (cash 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/Kinship ______Transfer_______SSI_____

Enrollment Information: Pathways __________ 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 ____________ 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)

Primary Clinic & City: ___________________________ **Primary Dentist & City:** ___________________________

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? ☐Family/Friend/Neighbor ☐Social Media/CAP Website ☐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.