Dear Parent/Guardian,

Thank you for your interest in our ARVAC Head Start/Early Head Start programs. The following are items you will need to bring upon returning the application to the nearest Head Start/Early Head Start program location:

- ❑ Date of Birth Documentation (one of the following:)
  - Birth Certificate
  - Hospital Records
  - DHS Paperwork or anything that is accepted as proof of birth by the government

- ❑ Proof of Residency (one of the following:)
  - Utility Bill
  - Phone Bill
  - Bank Statement
  - Insurance Statement
  - Rent Receipt
  - Check Stubs
  - Any legal document that lists applicant's name and current physical address.

- ❑ Proof of Income (one selection for all adults in the home:)
  - Pay stubs, SSI, TEA
  - Tax forms, W-2, or other income documents
  - A written statement from employer—we can supply a form if needed
  - If self-employed, a written statement describing your situation
  - **Or** SNAP documentation

- ❑ Immunization Record

Thank you for your time and patience and we look forward to working with you throughout this process.

Sincerely,

ERSEA Team

Enrolled Date: _____ Drop Date: _____ Re-enrollment Date: _____

For office use only

ARVAC, Inc. Head Start

HEAD START/EARLY HEAD START APPLICATION

Site Preference 1: _____ Site 2: _____ Program: ☐ EHS ☐ HS Program Year: _____

PARTICIPANT INFORMATION - Fill out information about the child applying to the program

_____ Birthday:____/____/____ ❑ Male ❑ Female

Last First Middle Name child will be called Age: Y____, Mo____, D____

_____ Parental Status: ☐ 1 ☐ 2

Living Address City State Zip

Child's Birthweight: _____ Premature: ☐ Yes ☐ No Gestational Weeks: _____

❑ American Indian/Alaska Native ❑ Asian ❑ African American ❑ Hawaiian Islander/Pacific Islander

❑ White ❑ Other: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ US Citizen Primary language spoken in the home: _____

FAMILY INFORMATION - Fill out information about parents/guardians and family

1. Primary Parent/Guardian:

_____ _____ Birthday: ____/____/____

Parent/Guardian Name Relationship to Child

_____ E-mail Address: _____

Living Address Mailing Address (If different) City State Zip

❑ American Indian/Alaska Native ❑ Asian ❑ African American ❑ Hawaiian Islander/Pacific Islander

❑ White ❑ Other: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ US Citizen Primary language spoken in the home: _____

Phone Numbers **(*Primary Phone):** _____ ❑ Cell _____ ❑ Home _____ ❑ Message/Other

Text Messages? ☐ Yes ☐ No Text Messages? ☐ Yes ☐ No Text Messages? ☐ Yes ☐ No

Teen Parent at time of child's birth **(19 or younger)**: ☐ Yes ☐ No Custody? ☐ Yes ☐ No

Education: ❑ GED (12 yrs) ❑ HS Diploma (12 yrs.) ❑ Associate's (14 yrs) ❑ Bachelor's (16 yrs) ❑ Master's (18-20 yrs)

❑ Some College. *If yes, what certificate/degree:* _____ Highest Grade/Ed. Level Completed: _____

English Level: ☐ None ☐ Poor ☐ Moderate ☐ Proficient

Employment Status--check all that apply: ❑ Full Time (35+) ❑ Part Time ❑ Currently in School/Training ❑ Retired/Disabled

❑ Seasonal ❑ Unemployed ❑ Unemployed over past 5 years Employer: _____ Work Hours: ____ - ___ *(ex. 8-5)*

2. Secondary Parent/Guardian - Lives with child?: ☐ Yes ☐ No

_____ _____ Birthday: ____/____/____

Parent/Guardian Name Relationship to Child

_____ E-mail Address: _____

Living Address Mailing Address (If different) City State Zip

❑ American Indian/Alaska Native ❑ Asian ❑ African American ❑ Hawaiian Islander/Pacific Islander

❑ White ❑ Other: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ US Citizen Primary language spoken in the home: _____

Phone Numbers **(*Primary Phone):** _____ ❑ Cell Text Messages? ☐ Yes ☐ No _____ ❑ Home Text Messages? ☐ Yes ☐ No _____ ❑ Message/Other Text Messages? ☐ Yes ☐ No

Teen Parent at time of child's birth **(19 or younger)**: ☐ Yes ☐ No Custody? ☐ Yes ☐ No

Education: ❑ GED (12 yrs.) ❑ HS Diploma (12 yrs.) ❑ Associate's (14 yrs.) ❑ Bachelor's (16 yrs.) ❑ Master's (18-20 yrs.)

❑ Some College. If yes, what certificate/degree: _____ Highest Grade/Ed. Level Completed: _____

English Level: ☐ None ☐ Poor ☐ Moderate ☐ Proficient

Employment Status--check all that apply: ❑ Full Time (35+) ❑ Part Time ❑ Currently in School/Training ❑ Retired/Disabled

❑ Seasonal ❑ Unemployed ❑ Unemployed over past 5 years Employer: _____Work Hours: ____ - ___ (*ex. 8-5)*

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*List **additional** family members *who lives in the home* and are *related to the applicant by blood, marriage, or adoption** *Please do not re-list those on page 1*

Name	Relation to Applicant	Male	Female	Birthdate
_____	_____	☐	☐	____/____/____
_____	_____	☐	☐	____/____/____
_____	_____	☐	☐	____/____/____
_____	_____	☐	☐	____/____/____
_____	_____	☐	☐	____/____/____
_____	_____	☐	☐	____/____/____

_____ **Total #** of people in household (including the child and adults listed on front and all listed above *who lives in child's household* and are part of his/her family.)

CHILD'S NEEDS: *Please provide medical documentation of concerns, if available.*

Is your child currently receiving any education/therapy services? ☐ Physical Therapy ☐ Occupational Therapy

☐ Developmental Therapy ☐ Speech Therapy ☐ Mental Health Counseling Please list provider(s): _____

_____

Does s/he have an Individual Education Plan or Individual Family Service Plan (IEP/IFSP)? ☐ Yes ☐ No

Do you have any suspected concerns about your child in any of these areas? Please check the appropriate item(s).

❑ Hearing ❑ Vision ❑ Allergies ❑ Asthma ❑ Dental Problems ❑ Under/overweight ❑ Seizures

❑ Anemia ❑ High Lead ❑ Diabetes ❑ Counseling/Mental Health ❑ Speech/Language/Developmental Therapy

❑ Physical Development ❑ Other medical/dental/nutritional problems or concerns? Please describe: _____

_____

❑ Mental Health, emotional (e.g., tantrums), or behavior concerns? Please describe: _____

_____

List all providers giving services: _____

❑ MY CHILD HAS NONE OF THE ABOVE NEEDS

Child's Primary Doctor: _____ Phone: _____ Date of Last Physical: _____

Child's Dentist: _____ Phone: _____ Date of Last Dental Check: _____

FAMILY NEEDS/SERVICES – Which services are you receiving?

❑ Food Stamps (SNAP) ❑ Foster Care/Adoption Subsidy ❑ Health/Mental Health Services ❑ Private Health Insurance

❑ WIC ❑ Child Support ❑ State Health Insurance/Medicaid #_____ ❑ Utility/Energy Assistance

❑ Emergency/Crisis Intervention ❑ Housing Services (Public Housing, Section 8) ❑ Specialized Women's Services

❑ Social Services referral or casework from another agency, if yes, please name agency/caseworker: _____

_____

Family is or has received services from Department of Child & Family Services. **(DCFS—child protective services)**? ☐ Yes ☐ No

Has your child been in Foster or Kinship Care? ☐ Yes ☐ No

Is your family living with drug/alcohol use, incarceration, child support concerns, domestic violence, Specialized Women's Services, and/or serious health or mental health concerns? ☐ Yes ☐ No If yes, please list name and concern(s): _____

Do you receive TEA ☐ Yes ☐ No Do you receive SSI? ☐ Yes ☐ No Do you receive Child Care Vouchers? ☐ Yes ☐ No

Has the child experienced a death in the past six (6) months? ☐ Yes ☐ No

Family Insured: ☐ Yes ☐ No Child Insured: ☐ Yes ☐ No

❑ NONE OF THE ABOVE

ADDITIONAL INFORMATION

Applicant has parent/guardian enlisted in active duty or has veteran status.? ☐ Yes ☐ No Relationship to child: _____

Is the Parent/Guardian an ARVAC staff member? ☐ Yes ☐ No

Are you or anyone in your family currently dealing with legal concerns such as family court, divorce, probation, custody, restraining orders, incarcerations, etc.? ☐ Yes ☐ No If yes, please list name and concern(s): _____

_____

Has child been enrolled in Head Start/Early Head Start or other child care program? ☐ Yes ☐ No

If yes, what HS/EHS program? _____

Has your child had a sibling previously enrolled in the HS/EHS program? ☐ Yes ☐ No

If yes, is s/he currently enrolled? ☐ Yes ☐ No Specify dates of attendance: _____ to _____

Is the child's mother currently pregnant? ☐ Yes ☐ No

Is the family experiencing *homelessness or been displaced in the past 2 years due to a hardship? If yes, please clarify:

_____

***Homelessness**= *living in a hotel, shelter, or with friends, etc.*

How did you hear about our program: ☐ Word of Mouth ☐ Received Flyer ☐ Staff Member/Passed the Center

❑ Social Media ☐ Referred by other Agency (WIC, child support services, etc.) Agency: _____

☐ Other: _____

Has your family been directly impacted by COVID-19? ☐ Yes ☐ No If yes, how? _____

_____

PLEASE SIGN: My signature below denotes that the above information is true and correct to the best of my knowledge. I understand that if this application is found to contain false information, the application could be rejected for enrollment.

_____ _____

Parent/Guardian Signature Date

_____

Printed Name

ARVAC, Inc. Head Start

EMERGENCY CONTACT INFORMATION

Child's Name:______________________________ Date of Birth: ______________

Address Lives At: ____

Parent/Guardian 1: ______________________________ Relationship to child: ______________

Home Address (if different): ____

Work Address: ____

Home Phone: ______________ Cell Phone: ______________ Work/Other: ______________

Parent/Guardian 2: ______________________________ Relationship to child: ______________

Home Address (if different): ____

Work Address: ____

Home Phone: ______________ Cell Phone: ______________ Work/Other: ______________

Authorized Contacts –*Please provide information for **<u>at least 2 people</u>** who are permitted to pick up your child from the ARVAC Head Start & Early Head Start program, and whom we can contact, if necessary, in an emergency. Please note that we must have a letter on file that documents our agreement to have an authorized contact under 18 years of age pick up your child.*

Please note that your child <u>will not</u> be released to anyone <u>not</u> on this list.

Name: ______________________________ Relationship to child: ______________

Address: ______________________________ ***Staff Initials:*** ________ ***Date:*** ____________

City State Zip

Phone: Home: (_____)______________ Cell: (_____)______________ Other: (_____)______________

Name: ______________________________ Relationship to child: ______________

Address: ______________________________ ***Staff Initials:*** ________ ***Date:*** ____________

City State Zip

Phone: Home: (_____)______________ Cell: (_____)______________ Other: (_____)______________

Name: ______________________________ Relationship to child: ______________

Address: ______________________________ ***Staff Initials:*** ________ ***Date:*** ____________

City State Zip

Phone: Home: (_____)______________ Cell: (_____)______________ Other: (_____)______________

Name: ______________________________ Relationship to child: ______________

Address: ______________________________ ***Staff Initials:*** ________ ***Date:*** ____________

City State Zip

Phone: Home: (_____)______________ Cell: (_____)______________ Other: (_____)______________

Is there a court order in place that restricts anyone from picking up your child? (Non-custodial parent or other adult due to restraining order, child' s foster or kinship status, etc.) Yes: ______ No: ______ If yes, please provide ARVAC HS/EHS with documentation, such as a copy of a court order to maintain in file and provide updates as needed.
NAME: ______________________________ ***RELATIONSHIP TO CHILD:*** ______________________

Is there any other person who may <u>try</u> to pick up your child who is <u>not</u> authorized to do so (i.e. but for whom there are no court papers)?
If so, please give ***NAME:*** ______________________________ ***RELATIONSHIP TO CHILD:*** ______________________

______________________________ ______________

Parent/Guardian Signature Date

The above information should be kept in classroom <u>and</u> child's file, updated at least twice/year and as needed.

ARVAC, Inc. Head Start

ADDITIONAL EMERGENCY CONTACT INFORMATION- OPTIONAL

Child Name: ____ Date of Birth: __________________

Address Lives At: ____

Authorized Contacts –*Please provide information for* ***additional people*** *who are permitted to pick up your child from the ARVAC Head Start & Early Head Start program, and whom we can contact, if necessary, in an emergency. Please note that we must have a letter on file that documents our agreement to have an authorized contact under 18 years of age pick up your child.*

Please note that your child will not be released to anyone not on this list.

Name: ____ Relationship to child: ______________
Address: ____ ***Staff Initials:*** ________ ***Date:*** ____________
City State Zip
Phone: Home: (_____)_______________ Cell: (_____)_______________ Other: (_____)_______________

Name: ____ Relationship to child: ______________
Address: ____ ***Staff Initials:*** ________ ***Date:*** ____________
City State Zip
Phone: Home: (_____)_______________ Cell: (_____)_______________ Other: (_____)_______________

Name: ____ Relationship to child: ______________
Address: ____ ***Staff Initials:*** ________ ***Date:*** ____________
City State Zip
Phone: Home: (_____)_______________ Cell: (_____)_______________ Other: (_____)_______________

Name: ____ Relationship to child: ______________
Address: ____ ***Staff Initials:*** ________ ***Date:*** ____________
City State Zip
Phone: Home: (_____)_______________ Cell: (_____)_______________ Other: (_____)_______________

Name: ____ Relationship to child: ______________
Address: ____ ***Staff Initials:*** ________ ***Date:*** ____________
City State Zip
Phone: Home: (_____)_______________ Cell: (_____)_______________ Other: (_____)_______________

Name: ____ Relationship to child: ______________
Address: ____ ***Staff Initials:*** ________ ***Date:*** ____________
City State Zip
Phone: Home: (_____)_______________ Cell: (_____)_______________ Other: (_____)_______________

Name: ____ Relationship to child: ______________
Address: ____ ***Staff Initials:*** ________ ***Date:*** ____________
City State Zip
Phone: Home: (_____)_______________ Cell: (_____)_______________ Other: (_____)_______________

____ ____________________
Parent/Guardian Signature Date

The above information should be kept in classroom and child's file, updated at least twice/year and as needed.