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

- ❑ Copy of Medicaid or Private Insurance Card

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

Sincerely,

ERSEA Team

Enrollment Date: _____

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: _____ ☐ US Citizen

Ethnicity: ☐ Hispanic ☐ Non-Hispanic 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: _____ ☐ US Citizen

Ethnicity: ☐ Hispanic ☐ Non-Hispanic 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 in household? ❑ 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: _____ ☐ US Citizen

Ethnicity: ☐ Hispanic ☐ Non-Hispanic 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*)

List **additional** family members *who live in the home* and are *related to the applicant by blood, marriage, or adoption* Please do not re-list those on page 1*
Using the following abbreviations, list race and ethnicity of each member in home not listed on page 1: *American Indian/Alaskan Native=AIAN, Asian=A, African American=AA, Hawaiian Islander/Pacific Islander=HIPI, White=W, Other=OT, Bi-racial=BR & list all that apply.* Ethnicity: *Hispanic=H, Non-Hispanic=NH*

Name	Relation to Applicant	Male	Female	Race	Ethnicity	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) ❑ WIC ❑ Child Support ❑ Foster Care/Adoption Subsidy ❑ Health/Mental Health Services

❑ Private Health Insurance # _____ ❑ 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 SSI? ❑ Yes ❑ No 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

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 <u>other</u> 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., due to extenuating circumstances.*

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: _____

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

No Earned Income Statement

To Whom It May Concern:

I,_____, at the time of submitting an application for my child,

_____, for enrollment in the

_____ ARVAC Head Start/Early Head Start, had no earned income

or unemployment benefits.

I became unemployed on_____.
(Month/Day/Year)

_____ _____
Signature Date

Declaración de no Tener Ingresos
(No Earned Income Statement)

A quien corresponda:

Yo,_____, en el momento de someter una aplicación para mi hijo/a,

_____, para matricularlo/a en el Centro de

_____ de ARVAC Head Start/Early Head Start, no tengo nada de ingresos

o beneficios de desempleo.

Fuí desempleaqdo en_____.
(Mes/Día/Año)

_____ _____
Firma Fecha

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 **at least 2 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: (______)______________

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 try to pick up your child who is not 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 and child's file, updated at least three times/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 three times/year and as needed.