 ***Cleveland County School District***

 *Cleveland County Head Start-ABC
 P.O. Box 600-700 Main Street*

 *Rison, AR 71665*

**Applicant Name*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Birthday** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*To pre-qualify for Head Start-ABC, the applicant child must be 3 or 4 years old by August 1st. Please attach a copy of the following information:* ***an up-to-date shot record, income verification, social security card, a copy of the child’s original birth******certificate****. (If you do not have a copy of the birth certificate, you may pick up an application at the Health Department or the Head Start Office) this application can NOT be processed until all of the above are turned in.* ***Proof of Insurance, AR Kids 1st, or Medicaid is also needed.***  *If you have any questions, please feel free to call our Central Office at 870-325-6324.*

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| *Child Information* |
| ***Last*** | ***First*** | ***Middle*** | *Preferred Name* | *Age* |
| Birthday | Gender | SSN | Alternate ID |
| *Race*🞏 Asian🞏 Black🞏 White🞏 Hispanic🞏 Other  | *English Proficiency* 🞏 Primary🞏 Poor🞏 Moderate 🞏 ProficientOther Language Spoken:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  ***Child’s Physician :*** *Name: Address: Phone:* |
|  ***Child’s Dentist:*** *Name: Address: Phone:* |
| *Date of child’s last physical exam: \_\_\_\_\_\_\_\_\_\_ Has your child received a lead test? \_\_\_\_\_\_\_* |
| *Date of child’s last dental exam: \_\_\_\_\_\_\_\_\_\_\_\_ Any concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
|  Child’s Medicaid # |  AR Kids 1st # | Private Health Coverage |  Dental Insurance | No Insurance |
| *Primary Adult – Family Information* |
| Last | First | Middle | Preferred | Suffix |
| Birthday | Gender  | SSN | e-mail address:  |
| *Race*🞏 Asian🞏 Black🞏 White🞏 Hispanic🞏 Other  | *English Proficiency* 🞏 Primary🞏 Poor🞏 Moderate 🞏 ProficientOther Language Spoken:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relationship to applicant:  |  Live in the same home as the child? Yes No |
| Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physical Address: ( if different)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   Home phone: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_   Work phone: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ |
| *Secondary Adult – Family Information* |
| Last | First | Middle | Preferred | Suffix |
| Birthday | Gender  | SSN | e-mail address: |
| *Race*🞏 Asian🞏 Black🞏 White🞏 Hispanic🞏 Other  | *English Proficiency* 🞏 Primary🞏 Poor🞏 Moderate 🞏 ProficientOther Language Spoken:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relationship to applicant:   |  Live in the same home as the child? Yes No  |
| Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physical Address: (if different)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  Home phone: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_   Work phone: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ |
| *Education/Employment Information:**Mother’s Level of Education: \_\_\_\_\_\_\_\_\_\_\_ Is mother currently enrolled in school or training program?\_\_\_\_\_\_\_\_**Is Mother Employed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Work Hours:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Father’s Level of Education:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is father currently enrolled in school or training program?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Is Father/Guardian Employed?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* *Work Hours:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Family Information*** |
| *Household Information (list everyone in the house with the child, attach an additional sheet (if necessary)* |
| ***Name*** | Sex  | Date of Birth | SSN | Relationship to child | Employed - In School (or both)***Please list name of school or employer*** ***and specify full or part-time status*** |
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| ***Family Income*** |
| *Are you receiving TANF or SSI? Yes No Are you a Military Family? Yes No* |
| *Does your family receive food stamps? Yes No Does your family receive WIC? Yes No* |
|  ***Family Per Verification Description***  ***Member Amount (Week-Month-Year) Annual Amount (for ex. W2-check stub) (for ex. SSI, Job, Child Support)***  |
|  $ $ |
|  $ $ |
|  $ $ |
|  $ $ |
|  |
| ***Notes:*** |
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|  |  ***Emergency Contacts*** ***(Please complete entire section)*** |
|  ***Contact 1*** | *Name: Relationship: Release To: Yes No*  |
| *Address: City: State: Zip Code:* |
|  *Phone #1: Phone #2: Phone #3: Cell Home Work Cell Home Work Cell Home Work* |
|  ***Contact 2*** | *Name: Relationship: Release To: Yes No*  |
| *Address: City: State: Zip Code:* |
| *Phone #1: Phone #2: Phone #3: Cell Home Work Cell Home Work Cell Home Work* |
| ***Contact 3*** | *Name: Relationship: Release To: Yes No*  |
| *Address: City: State: Zip Code:* |
|  *Phone #1: Phone #2: Phone #3: Cell Home Work Cell Home Work Cell Home Work* |

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| *Does this child live with?* *1 parent 2 parents guardian grandparent foster parent joint custody other* |
| *Does your child have any diagnosed disabilities? (Speech, hearing, vision, etc.)* |
| *Does your child have any significant allergies? (Medication, food, etc.)* |
| *Will your child need Head Start to administer any prescribed medications during the day?* |
| *Does your child or family need a referral for medical or dental services?* |
| *Does your child receive mental health counseling or treatment?* |
| *If (yes) please explain:* |
| *Is either biological parent of the applicant (child) currently incarcerated?* |
| Directions to your home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| *Will your child need transportation? Yes No* *Note: Transportation may not be available in some areas.* |
| *How did you hear about our program?*  *Former Parent Friend Referral Walk-In Newspaper Other* |
| *If other, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |

***Certification:*** *I hereby certify that this information is true. If any part is false, my participation in this agency’s programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.*

***Parent/Guardian Signature Date***

*Enrollment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drop Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Transfer Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reenrollment Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Center Hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Center: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*