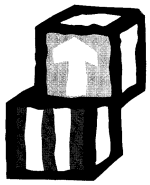
☐ **Referral**

CAP | COMMUNITY ACTION PARTNERSHIP OF SCOTT CARVER & DAKOTA COUNTIES

2015 - 2016
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

This is only an application and does not mean your child is enrolled

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)
☐Centerbased ☐Homebased
☐ Early Head Start – Ages prenatal to 3 years old (home visit program)

*****Parent/guardian must provide transportation*****

Preferred Location/s: ☐ Rosemount ☐ Apple Valley ☐ Savage
☐ S.St.Paul ☐ Eagan ☐ Chaska
☐ Inver Grove Heights ☐ Shakopee

Number of individuals in the household _____

Parent/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	☐Cell ☐Home ☐Work	☐Cell ☐Home ☐Work
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	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

☐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, 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.** ☐ Moved more than 3 times in 12 months
- **I.** ☐ Other: _____

Family Information:

☐ One Parent Household ☐ Two Parent Household ☐ Foster Parent(s)*

(** 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.

Family Member 02

First Name:	**Last Name:**		**U S Military Member:** 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)

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 <u>before your application can be processed.</u> <u>Please include the following with your application:</u>

* 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/Alimony
☐ Unemployment ☐ Social Security ☐ SSI ☐ MFIP/TANF/DWP
☐ Interest/Other ☐ Self Employment ☐ No Income

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_____

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

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

Reminder: This is only an application and does not mean your child is enrolled.

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

Legal name of child you wish to enroll:

_____ _____ _____
First **Middle** **Last**

Does your child go by any other name? Yes /No Please List: _____

Child's Birth Date: _____ / _____ / _____ Male / Female (circle one)
Month Day Year

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/Condition: _____

_____

Specify medications child is currently taking: _____

*Does your child have a special need? Yes / No Explain _____

_____

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

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

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)

Return application 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.