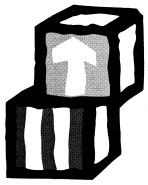
☐ **Referral**

CAP | COMMUNITY ACTION PARTNERSHIP OF SCOTT CARVER & DAKOTA COUNTIES

2021-2022
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:
☐ Farmington ☐ Apple Valley ☐ Savage
☐ W. St. Paul ☐ Eagan ☐ Chaska
☐ Inver Grove Heights ☐ Rosemount ☐ Shakopee

Number of individuals in the household _____
Is anyone in the household pregnant? ☐/☐ **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 ☐ 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**: ☐ / No☐ Full or Part Time?		**Parent In School or Training:** ☐ / 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(cash)	☐ 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 ☐ cle 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 Early/Head Start before? ☐ Yes / ☐ No If yes, when? _____ 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 -or- headstart@capagency.org

If you need help completing this application:

Please call 651-322-3500.

Hearing impaired use MN Relay Service 1-800-627-3529.

Parent Aware Rated Program

Highest Possible Rating