

**COMMUNITY PROGRESS COUNCIL, INC.
HEAD START OF YORK COUNTY
CHILD APPLICATION FORM**

CHILD'S NAME: _____ DOB: _____
 SOCIAL SECURITY NUMBER: _____ RACE: _____ Gender: ___F___M
 ADDRESS: _____ APT# _____
 CITY: _____ ZIP CODES: _____ SCHOOL DISTRICT: _____

PRIMARY LANGUAGE: ENGLISH SPANISH OTHER _____
PLEASE PROVIDE AT LEAST ONE (1) CONTACT PHONE NUMBER

HOME PHONE	CELL PHONE	OTHER TELEPHONE
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MOTHER/GUARDIAN INFORMATION (circle one)

NAME: _____ DOB: _____
 ADDRESS (If different from child): _____

HOME PHONE	WORK TELEPHONE	CELL PHONE	OTHER TELEPHONE
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HOURS AT WORK/SCHOOL PER WEEK: _____ CONSECUTIVE MONTHS OF EMPLOYMENT _____

FATHER/GUARDIAN INFORMATION (circle one)

NAME: _____ DOB: _____
 ADDRESS (If different from child): _____

HOME PHONE	WORK TELEPHONE	CELL PHONE	OTHER TELEPHONE
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HOURS AT WORK/SCHOOL PER WEEK: _____ CONSECUTIVE MONTHS OF EMPLOYMENT _____

FAMILY SIZE:	CURRENTLY RECEIVING TANF? <input type="checkbox"/> YES <input type="checkbox"/> NO	CURRENTLY RECEIVING SSI? <input type="checkbox"/> YES <input type="checkbox"/> NO	FOSTER CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO EDUCATIONAL RIGHTS? <input type="checkbox"/> YES <input type="checkbox"/> NO
AT THE TIME OF YOUR INITIAL INTAKE APPOINTMENT, YOU WILL BE ASKED TO PROVIDE PROOF OF INCOME.	INCOME TYPE <input type="checkbox"/> Wages <input type="checkbox"/> TANF <input type="checkbox"/> Child Support <input type="checkbox"/> Unemployment <input type="checkbox"/> Retirement <input type="checkbox"/> SSI <input type="checkbox"/> Disability <input type="checkbox"/> Other		TOTAL YEARLY INCOME \$

ARE YOU CURRENTLY INVOLVED WITH CHILDREN & YOUTH SERVICES? YES NO
 CASE WORKER'S NAME: _____
 IS YOUR CHILD TRANSFERRING FROM ANOTHER HEAD START? YES NO **WHERE:** _____

PARENT SIGNATURE: _____ DATE: _____

PROCESSED: INITIAL _____ DATE ___/___/___

ATTEMPTS TO CONTACT FOR ENROLLMENT

1st attempt 2nd attempt 3rd attempt b1

FCP: APPLICANT INFORMATION
 RETURN PATH: ORIGINAL – CHILD'S FILES
 COPY – ERSEA SPECIALIST

REVISED 3/20/2008

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CIRCLE ALL THAT APPLY		HS NOTES
DO YOU HAVE ANY SPECIAL NEEDS OR CONCERNS FOR YOUR FAMILY, SUCH AS:	EDUCATION/TRAINING/LITERACY EMPLOYMENT LEGAL SERVICES PARENTING SUPPORT COUNSELING SUBSTANCE ABUSE DOMESTIC VIOLENCE MENTAL HEALTH PREVIOUS INVOLVEMENT WITH CHILDREN & YOUTH	
ARE YOU A:	FOSTER PARENT GUARDIAN/ GRANDPARENT OF CHILD SINGLE PARENT TEEN PARENT (Currently 18 or younger) TWO PARENT HOUSEHOLD	
ARE YOU A:	WORKING PARENT TRAINING PARENT	
IS MOTHER PREGNANT OR IS THERE A NEWBORN IN FAMILY?	PREGNANT NEWBORN (<i>under 1 year old</i>)	
IS YOUR FAMILY:	HOMELESS IN A SHELTER	
DO YOU NEED HELP FINDING WAYS TO MEET BASIC NEEDS LIKE:	HEALTH INSURANCE UTILITY SHUT OFF NOTICES	
DOES YOUR CHILD HAVE AN EDUCATIONAL, MEDICAL OR MENTAL HEALTH DIAGNOSIS? (ATTACH COPY OF ER, IEP OR PROOF OF DIAGNOSIS)	EDUCATIONAL DIAGNOSIS MENTAL HEALTH DIAGNOSIS MEDICAL DIAGNOSIS	
DO YOU HAVE A DEVELOPMENTAL OR BEHAVIORAL CONCERN FOR YOUR CHILD?	SPEECH or FINE/GROSS MOTOR, ETC BEHAVIORAL	
TO BE COMPLETED BY HEAD START STAFF		
ELIGIBILITY BY AGE	KINDERGARTEN BOUND 2 YEARS OF SERVICE	
	TRANSFERRING FROM ANOTHER HEAD START	
	FAMILY IS INVOLVED WITH CHILDREN AND YOUTH AGENCY	
CHILD HAS SPECIAL NEED MEETING HEAD START CRITERIA FOR MEDICAL NEEDS, OR MEETS DISABILITY REGULATIONS, SUCH AS:	ER/IEP WITH ED. CONSULT ER/IEP WITH SPEECH RELATED SERVICE OF OT , PT, VISION ITINERANT, HEARING ITINERANT MENTAL HEALTH DIAGNOSIS OTHER HEALTH IMPAIRMENT	
RECEIVED REFERRAL BASED ON THE SUSPICION OF CHILD'S UNMET NEEDS, SUCH AS:	MEDICAL COMMUNITY, SOCIAL SERVICES, CHILD DEVELOPMENT PROGRAM, CHURCH GROUP OR STATE HEALTH AGENCIES.	

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