

COMMUNITY PROGRESS COUNCIL, INC.
EARLY HEAD START/HEAD START OF YORK COUNTY
 226 E. College Avenue York PA 17403
PREGNANT MOTHER/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: _____
 REFERRED BY: _____

PROCESSED: INITIAL _____ DATE ____/____/____

ATTEMPTS TO CONTACT FOR ENROLLMENT

1 st attempt	2 nd attempt	3 rd attempt

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CIRCLE ALL THAT APPLY		HS NOTES
DO YOU HAVE ANY SPECIAL NEEDS OR CONCERNS FOR YOUR FAMILY, SUCH AS:	INCARCERATED PARENT EDUCATION/TRAINING/LITERACY EMPLOYMENT LEGAL SERVICES PARENTING SUPPORT COUNSELING SUBSTANCE ABUSE DOMESTIC VIOLENCE MENTAL HEALTH	
ARE YOU A:	FOSTER PARENT GUARDIAN/ GRANDPARENT OF CHILD SINGLE PARENT TEEN PARENT (Currently 19 or younger) TWO PARENT HOUSEHOLD	
ARE YOU A: Please provide documentation (schedule/pay-stub)	WORKING PARENT ATTENDING SCHOOL/TRAINING PARENT	
IS MOTHER PREGNANT OR IS THERE A NEWBORN IN FAMILY?	PREGNANT NEWBORN (<i>under 1 year old</i>)	
IS YOUR FAMILY:	HOMELESS LIVING WITH FAMILY IN A SHELTER	
DO YOU NEED HELP FINDING WAYS TO MEET BASIC NEEDS LIKE:	HEALTH INSURANCE UTILITY SHUT OFF NOTICES FOOD	
DOES YOUR CHILD HAVE AN EDUCATIONAL, MEDICAL OR MENTAL HEALTH DIAGNOSIS? (ATTACH COPY OF ER, IFSP, IEP OR PROOF OF DIAGNOSIS)	EDUCATIONAL DIAGNOSIS MENTAL HEALTH DIAGNOSIS MEDICAL DIAGNOSIS	
DO YOU HAVE A DEVELOPMENTAL OR BEHAVIORAL CONCERN FOR YOUR CHILD OR YOURSELF?	SPEECH or FINE/GROSS MOTOR, ETC BEHAVIORAL SUBSTANCE ABUSE POST PARTUM DEPRESSION	
DOES THIS CHILD HAVE A SIBLING(S) THAT HAS ATTENDED HEAD START? YES/NO	Sibling Name: Date of Birth of Sibling:	
TO BE COMPLETED BY HEAD START STAFF	TO BE COMPLETED BY HEAD START STAFF	
<u>Potential Number of Service Years:</u> 1, 2, 3, 4, 5	TRANSFERRING FROM ANOTHER HEAD START OR EARLY HEAD START	
FAMILY IS INVOLVED WITH <u>CHILDREN AND YOUTH AGENCY</u>	SIGN UP: WIC, MEDICAL ASSISTANCE, TANF, Food Stamps	
CHILD HAS SPECIAL NEED MEETING HEAD START CRITERIA FOR MEDICAL NEEDS, OR MEETS DISABILITY REGULATIONS, SUCH AS:	ER/IFSP/IEP WITH ED. CONSULT ER/IFSP/IEP WITH SPEECH RELATED SERVICE OF OT , PT, VISION ITINERANT, HEARING ITINERANT, SPEECH MENTAL HEALTH DIAGNOSIS OTHER HEALTH IMPAIRMENT	

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