

FOR OFFICE USE ONLY: No _____ Date Accepted _____ Enrl. Date _____ Reenroll Date _____

AM _____	PM _____	4hr _____	HB _____	Eligibility Verification _____	Birth Date Verification _____		
5hr/SY _____	5hr _____	6hr _____	2/2 _____AM/PM	Ret Child _____	Ret Family _____	Sib _____	Number years participated 1 2 3 (circle one)

BLAIR COUNTY HEAD START ENROLLMENT APPLICATION

Child's Name _____ **DOB:** _____ **Child's S.S.#** _____
Last First MI

This information is used to make sure we are effectively reaching all races and ethnicities. This will not impact your child's eligibility. **Circle all that apply:**

Race: African American Asian White/Caucasian Native Alaskan/American Indian Native Hawaiian/Pacific Islander Asian Other _____

Ethnic Origin: Hispanic Non Hispanic **Sex:** Male Female

Address _____ **Phone:** _____ **Cell:** _____
Street, P.O. Box, or RD # City State Zip Code

	<u>Name</u>	<u>DOB</u>	<u>Social Security #</u>	<u>Occupation</u>	<u>Empl.Status</u>	<u>Educ. Level</u>	<u>Current Student</u>
<input type="checkbox"/>	Mother _____	_____	_____	_____	FT PT Unemployed _____	_____	FT PT
<input type="checkbox"/>	Father _____	_____	_____	_____	FT PT Unemployed _____	_____	FT PT
<input type="checkbox"/>	Other _____	_____	_____	_____	FT PT Unemployed _____	_____	FT PT

Is there Court Order Custody:

Yes _____ No _____
If yes, who? _____

Child lives with

Mother _____ Father _____ Step Mother _____ Step Father _____
Grandparents _____ Guardian _____ Foster Parents _____

Marital Status

Single _____ Married _____ Divorced _____
Separated _____ Widow/Widower _____ Other _____

Other children in household:

Name	DOB
1. _____	_____
2. _____	_____
3. _____	_____

Other persons in the household:

Name	Relationship to child
1. _____	_____
2. _____	_____
3. _____	_____

Does anyone in your family receive:

Public Assistance/TANF	Yes	No
Social Security Income	Yes	No
WIC	Yes	No

Family Size _____ **Eligible for Childcare subsidy** _____

If you cannot be reached, whom may we contact about your application?

	Name	Phone	Relationship to Child
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Has your child received services from any of the following agencies?

<input type="checkbox"/> Children & Youth Services (Child Services)	Early Intervention with:	Mental Health service with:	
<input type="checkbox"/> The Learning Express (A.A.S.D.)	<input type="checkbox"/> Home Nursing	<input type="checkbox"/> Canal Ways	<input type="checkbox"/> Meadows
<input type="checkbox"/> IU8	<input type="checkbox"/> North Star Support Services	<input type="checkbox"/> Home Nursing	<input type="checkbox"/> Blair Family Solutions
<input type="checkbox"/> Day Care, Child Care, Nursery or Preschool	<input type="checkbox"/> Altoona Hospital (Speech)	<input type="checkbox"/> Altoona Hospital	<input type="checkbox"/> Nulton/Childrens Behavior
Name: _____	<input type="checkbox"/> Easter Seals	<input type="checkbox"/> Other: _____	

Has your child had any evaluations/or in the process of an evaluation? Yes ___ No ___ Where? _____

Do we have your permission to contact the agency: Yes ___ No ___

Does your child have any behavior, emotional or medical problems or concerns? _____

Does your child have any speech problems? (Explain) _____

Can you understand your child? _____ Can others understand your child? _____

Directions to your home if outside city or town: _____

The above information is accurate to my knowledge; I understand that incorrect information could lead to dismissal of my child from the program. I understand that completion of this application does not guarantee enrollment into the program. If accepted I also intend to participate fully in the program.

Parent/Legal Guardian Signature _____ Date _____ Email address: _____

Head Start enrolls children regardless of race, color, religious creed, disability, ancestry, national origin, or genders.