LRDA EARLY/HEAD START APPLICATION

LRDA EHS/HS Promotes School Readiness

Primary Caregiver

First Name: _____ Last Name: _____
Gender: _____ Birth Date: _____
Relationship to Applicant: _____

Family Information

Family Type: ◯ One Parent ◯ Two Parent ◯ Teen Parent

Address: _____
City: _____ State: _____ Zip Code: _____
No. in Family: _____ # Of Children: _____
Home Phone Number: _____ Cell Phone Number: _____

Applicant General Information

First Name: _____ Middle Name: _____
Last Name: _____ Other Name: _____
Gender: _____ Suffix: _____
Birth Date: _____ Place of Birth: _____
School Year: _____

Ethnicity

Race: ◯ American Indian or Alaska Native ◯ Asian ◯ White ◯ Other
◯ Black or African American ◯ Native Hawaiian ◯ Biracial/Multi-Racial

Ethnicity: ☐ Hispanic or Latino

Language

English Proficiency ◯ Very Well ◯ Well ◯ Not Well ◯ Not at All

☐ Speak English at Home _____
Primary Language _____
Secondary Language _____

Family PIR

Federal or Other Assistance:	☐ Receive TANF? ☐ Receive SSI?
If not Receive TANF	☐ Received Cash Aid within the last Two Years Date of Last Cash Aid Payment _____
Family Partnership Process:	☐ Does Family Participate in family Partnership Plan?
Family Services Received During Operating Period:	☐ Emergency / Crisis Intervention ☐ Housing Assistance ☐Transportation Assistance ☐Mental Health Services ☐ ESL Training ☐ Adult Education ☐ Job Training ☐ Child Abuse & Neglect Services ☐ Child Support Assistance ☐ Domestic Violence Services ☐ Marriage Education ☐ Parenting Education ☐ Health Education (including prenatal) ☐Child Development ☐ Assistance to Families of Incarcerated Individuals ☐Employment ☐Substance Abuse Prevention or Treatment ☐Discipline
WIC Participation:	☐ Does Family Receive WIC Services?
Father Involvement:	☐Did Father/Father Participate in Agency Father Involvement Activities?
Services to Homeless Families:	☐ Was family homeless during current school year? ☐ Was family homeless & acquired housing this school year?

	Father Caregiver	Mother Caregiver
Training	☐ In Training / In School	☐ In Training / In School
Education Level	◯ Less than high School/No Diploma ◯ High School Graduate / GED ◯ Some College – Vocational School ◯ Bachelor or Advanced Degree	◯ Less than high School/No Diploma ◯ High School Graduate / GED ◯ Some College – Vocational School ◯ Bachelor or Advanced Degree
Employment Status	☐Employed	☐Employed
Reasons for needing Child Care	☐ Medically Incapacitated/Disabled ☐ Looking For Work ☐ Homeless / Seeking Housing ☐ Migrant Worker	☐ Medically Incapacitated/Disabled ☐ Looking For Work ☐ Homeless / Seeking Housing ☐ Migrant Worker

Health Insurance

Primary Health Insurance

◯ No Insurance
◯ Medicaid / EPSD
◯ SCHIP
◯ Combined SCHIP / Medicaid
◯ State Only Insurance
◯ Private Insurance
◯ Other Health Insurance

Obstetrical and Neonatal History (Prenatal Moms Only)

☐ Exposure/Use of Drugs, Alcohol, Smoking, or Other
(If Yes, explain below)

Month Prenatal Care Began _____ Weeks Pregnant _____ Birth Weight _____
Delivery Method _____ Hours in Labor _____ Days in Hospital _____
Pregnancy Complications current or previous: Bleeding _____
Headache _____ C- Section _____
Swelling _____ Fatigue _____
Sickle Cell _____ Pre- Term Labor _____
Hypertension _____ Diabetes _____
Preg-Induced Hypertension _____ Anemia _____
Neonatal Death _____ Pregnancy Notes: _____
_____

Child's Past Medical History

☐Seizures/Convulsions
☐Hospitalization
☐Surgeries
☐Orthopedic Problems
☐Pneumonia
☐Asthma
☐Lead poisoning
☐Visual Problems
☐Hearing Problems
☐Allergies

☐Rheumatic Fever
☐Frequent Ear Infections
☐Frequent Colds
☐Sore Throat
☐ Sickle Cell
☐Cancer
☐Leukemia
☐Tuberculosis
☐Bleeding Disorder
☐Anemia

☐Gastro esophageal Reflux (GER)
☐Heart Disease
☐Kidney Disease
☐Diabetes
☐Hepatitis
☐Mumps
☐Rubella
☐Whooping Cough
☐Meningitis
☐Chicken Pox

☐ Liver
☐ Overweight

Family Medical History (Immediate Family)

□Allergies	□Hypertension	□Sexually Transmitted Disease	
□Asthma	□Kidney Disease	□Drug Use	□High Blood
□Lung Disease	□Mental Illness	□Alcoholism	□ Heart Disease
□Visual Impairment	□Developmental Disabilities	□Smoking	□Hepatitis
□Epilepsy	□Pregnant Mother	□Bleeding Disorder	□Diabetes
□Due Date	□Hearing Impairment	□Cancer	□Chemical Exposure
□Anemia	□Multiple Sclerosis	□Tuberculosis	□Epilepsy
□Hepatitis	□Pregnant Mother	□Bleeding Disorder	□Diabetes
□Due Date			

Comments:

Prenatal Care (Prenatal Moms Only)

Due Date _____ Delivery Date _____
Obstetrical _____ Health Funding Source _____
Insurance Provider _____ Insurance Policy Number _____
Last Prenatal Visit _____ Last Dental Exam _____

Does the applicant receive information on benefits of breastfeeding? ◯ No ◯ Yes
Did applicant receive Mental Health Intervention? ◯ No ◯ Yes
Did applicant receive Prenatal/ Post-Partum Care? ◯ No ◯ Yes
Did applicant receive Fetal Development education? ◯ No ◯ Yes
Did applicant receive Substance Abuse Prevention & Treatment? ◯ No ◯ Yes

Enrollment Trimester ◯ First ◯ Second ◯ Third

Comments:

Family Members

Last Name / First Name	Relationship	Birth Date

Family Income

	Primary Caregiver	Secondary Caregiver
Work/Employment		
Child Support		
Spousal Support		
Parent Support		
State Disability		
Unemployment Benefits		
Sales/Work Commissions		
Cash Aid/TANF		
Workers Compensation		
Social Security		
SSI/ SSP		
Other		
Specify Other		
YEARLY INCOME		

Eligibility Criteria

□ (-) than High School Diploma (Caregiver) □Homeless □Parental Loss by Death
□12-24 months by August 31st □Incarcerated Parent □Potential or Suspected Disability
□24-36 months by August 31st □Income Eligible 100% & lower □Prior Waiting List Applicant
□3 years old by: August 31st □Income Eligible 101% - 130% □Recommendation by Com. Program
□4 years old by: August 31st □Medicaid □ Returnee- 4 years or older
□6 weeks-18 months by August 31st □Not the Individual's parent □SSI
□English as a Second Language □One Parent □TANF
□Family w/3 Children under age 5 □Other Diagnosed (document) □Teen Parent (12-18)
□Food Stamps □Over Income □Two Parent
□Foster Child □Parent is Currently an EHS Participant □WIC
□Foster Parents □Parent is Currently as HS Participant □Zero Disability
□ Parent with a Disability

Total: ☐

Directions From the Center:

_____
_____
_____
_____

Signature Section:

Parent

I certify that information provided is correct to the best of my knowledge and is subject to verification. I am also aware that I may be subject to termination form the program if the information verified disqualifies me from eligibility.

Parent's Signature & Printed Name Application Date:

Padre/ Madre

Yo certifico que la informacion provista es correcta hasta lo major que conozco y sujeta a verificacion. Tambien se que puedo estar sujeto a terminacion del programa si la informacion verificada me descalifica de la elegibilida.

Firma del Aplicante Nombre (Use letra imprenta) Fecha

Agency Signatures

Center Director's Certification Signature: Certification Date:

_____ _____

Print Name of Center Director:

Staff's Eligibility Verification Signature: Verification Date:

_____ _____

Print Name of Staff Member:

_____

Needed Materials: ◯ Medicaid Card ◯ Income ◯ Shot Record ◯ Birth Certificate

Transportation Provided: Within a 5 Mile Radius from the Center