WAGES Early Head Start Application

Application Date: _______________ **School Yr Applying for:** _____________ **Enrollment Date:** _______________

☐ 1st year
☐ 2nd year
☐ 3rd year

CHILD and FAMILY INFORMATION

Child's Legal Name: Last	**First**	**Middle**
Child's Social Security Number:	**Date of Birth:**	
Child's Gender: ☐**Male** ☐**Female**	**Preferred Name:**	
Name of Person(s) Child Lives With:	**Relationship to child:**	
Street Address:	**Mailing Address:** (if different)	
City: **State:**	**Zip Code:** **County:**	
Phone: ☐ **Home** ☐**Message** ☐ **Cell** ☐ **Beeper/Pager** ( ) -	**Alternate Phone:** ☐ **Home** ☐**Message** ☐ **Cell** ☐ **Beeper/Pager** ( ) -	
Is child a United States resident? ☐ **Yes** ☐ **No**	**Is child a North Carolina resident?** ☐**Yes** ☐ **No**	

MEDICAL INFORMATION

Child's Doctor:	**Office Phone:**	**Address:**
Child's Dentist:	**Office Phone:**	**Address:**

Preferred Hospital:

Please indicate which insurance this child currently receives? ☐ **Medicaid** ☐ **NC HealthChoice** ☐ **TriCare** ☐ **Private** ☐ **None**

If applicable, please list insurance number:

Which of the following Health concerns or problems relate to this child?

☐ Behavior/Emotional Problems ☐ Medically Fragile ☐ Developmental Delays ☐ Allergies ☐ Rashes ☐ Fears
☐ Seizures/Convulsions ☐ Hyperactivity ☐ Chronic Health Problems (such as Asthma, Diabetes, Arthritis)
☐ No significant health concerns

List any medications child currently takes:

EMERGENCY CONTACTS/CHILD RELEASE INFORMATION

Please list emergency contacts and/or persons to whom this child may be released to (other than parent/guardian):

#					
1	☐ *Contact*	**Name:**	**Address:**	**Phone:** ( )	
	☐ *Release*	**Relationship:**	**City:**	**State:**	**Zip:**
2	☐ *Contact*	**Name:**	**Address:**	**Phone:** ( )	
	☐ *Release*	**Relationship:**	**City:**	**State:**	**Zip:**
3	☐ *Contact*	**Name:**	**Address:**	**Phone:** ( )	
	☐ *Release*	**Relationship:**	**City:**	**State:**	**Zip:**
4	☐ *Contact*	**Name:**	**Address:**	**Phone:** ( )	
	☐ *Release*	**Relationship:**	**City:**	**State:**	**Zip:**
5	☐ *Contact*	**Name:**	**Address:**	**Phone:** ( )	
	☐ *Release*	**Relationship:**	**City:**	**State:**	**Zip:**
6	☐ *Contact*	**Name:**	**Address:**	**Phone:** ( )	
	☐ *Release*	**Relationship:**	**City:**	**State:**	**Zip:**
7	☐ *Contact*	**Name:**	**Address:**	**Phone:** ( )	
	☐ *Release*	**Relationship:**	**City:**	**State:**	**Zip:**
8	☐ *Contact*	**Name:**	**Address:**	**Phone:** ( )	
	☐ *Release*	**Relationship:**	**City:**	**State:**	**Zip:**

In the event of an emergency, I give my permission for provider to secure needed emergency medical care in the event that neither the family physician nor I can be contacted immediately. I further understand that emergency medical care may be obtained from the closest available emergency room facilities, regardless of parent/guardian preference expressed to provider.

Parent/Guardian Signature: ____ **Date:** _______________

CHILD & FAMILY INFORMATION

Child's Race: □ Black □ White □ Biracial/Multiracial □ American Indian/Alaska Native □ Pacific Islander □ Asian
□ Hispanic/Latino □ Other (please indicate: _)

Parent's Race: □ Black □ White □ Biracial/Multiracial □ American Indian/Alaska Native □ Pacific Islander □ Asian
□ Hispanic/Latino □ Other (please indicate:)

Child's Ethnicity: □ Hispanic or Latino origin (Cuban, Mexican, Puerto Rican, or other Spanish culture or origin)
□ Non-Hispanic/Non-Latino origin

Primary Language spoken at home: □English □Spanish □Other (please indicate:)

Secondary Language spoken at home: □English □Spanish □Other (please indicate: _________________________)
Proficiency: □Poor □Moderate □Proficient

Family preference for written communication: □English □Spanish □Other (please indicate:)

Parental Status: □ One parent □ Two parent □ Foster □ Non-Parent □Other

Total Family Size? ________ **Total Household Size (how many people live on the income listed on this application)?** _______
□ Mother □Father □Number of Children_____ □ Other Adults (age 18+) How many?

Does your family receive assistance from any of the following?
□ AFDC/TANF □ Food Stamps □ Free/Reduced price School Meals

ADULT DEMOGRAPHIC INFORMATION

First and Last Name Enter Primary Adult First	**Date of Birth**	**Social Security #**	**Sex**	**Marital Status**	**(D1) Educ Level**	**(D2) Employ Status**	**(D3) Notes Name of Employer, Or Occupation**
			M F				
			M F				

Marital Status Codes

S - Single **M - Married**
D - Divorced **DS - Deployed Spouse**
Other _____________________

D1 – Education Level

G9 = Grade 9(or less) **GED** **AA** = Associates
G10 = Grade 10 **COL** = Some College **BA** = Bachelors
G11= Grade 11 **DRP** = Dropped out **MA** = Masters
STU = In High school **HSG** = High school Graduate

D2- Employment Status

U= Unemployed **T**= Student in School
F= Full Time work **P**= Part Time work
B= F-time & student **L**= P-Time & student
M=Medical Leave **R**= Retired/ Disabled
S= Seasonal work **Other** ___________

If employed, how long has mother (or primary caregiver) been at current job?
□ < 90 days □ 3–12 months □ 13-18 months □ 19-24 months □ more than 2 years
If employed, how long has father (or secondary caregiver) been at current job?
□ < 90 days □ 3–12 months □ 13-18 months □ 19-24 months □ more than 2 years

CHILD DEMOGRAPHIC INFORMATION

First and last name of children in home *(If more than 4, please check ____ and list remaining on back of application)*	Date of Birth	Social Security #	Sex	(D1) Related to	(D2) How Related	(D3) Notes e.g., program participation status, other programs, etc.
C01 ---------**program applicant**-----------------	-------------------	----------------------	------			
C02			M F			
C03			M F			
C04			M F			
C05			M F			

C06			M F			
C07			M F			
C08			M F			

(D1) Related to Codes	(D2) How Related	(D3) Participation Status Codes
A01 - Primary Adult **A02** - Second Adult **B12** - Both Adults (includes step-parents)	**C** = Natural Child **F**= Foster Child **G** = Grandchild **N**= Niece/Nephew	**A**= Applied Child **Y**= Too Young **N**= Next Yr Elig. **O**= Too Old

ADDITIONAL INFORMATION

Indicate which of the following agencies this child has previously received or currently receives services from:

- □ **None**
- □ **Child Service Coordination**
- □ **Public Schools (List county, state_______________________)**
- □ **Children's Developmental Services Agency (DEC)**
- □ **Mental Health**
- □ **Early Childhood Intervention**
- □ **Other? ____**

SPECIAL NEEDS INFORMATION

Does this child have a disability or special need? □**Yes** □ **No** □ **Suspected**

If Yes, what is diagnosis: ______________________________ Comments: ____

Does child already have an IEP or IFSP? □Yes □ No Date of Plan: ____

Is child receiving services related to disability? □ Yes □ No

If NO, has child been referred to services related to disability? □ **Yes** □ **No**

If Yes, who has child been referred to?

Optional: Any specific family need or crisis? □**Yes** □ **No** (If yes, please explain:)

PLACEMENT LOCATION INFORMATION

What is your site preference? (please number first four choices from most to least favorite)

____ **Carver Early Head Start**
____ **Chestnut Street Early Head Start**
____ **Herman Street Early Head Start**
____ **Royall Avenue Early Head Start**
____ **Royall West Early Head Start**
____ **Other ___________________________________**

Is child currently in childcare or other pre-K setting? □**Yes** □ **No** **If yes, where: _____________________How long? _______**

Has child ever been in childcare or other pre-K setting? □ **Yes** □ **No** **If yes, where: _____________________How long? _______**

TRANSPORTATION INFORMATION

Will transportation be needed? □ **Yes** □ **No**

If Yes, list Pick-up Location: ____

list Drop-off Location: ____

If No, how would child get to school? □ Walk-in □ Other □ Parent **Parent's Initials:**

RECRUITMENT INFORMATION

How did you learn about our program? □ Flyer, Brochure, Poster □ Staff Person □ Word of mouth □ Radio/TV/Newspaper □ Family Friend □ Other: ________________

EXTENDED DAY CHILD CARE INFORMATION

Does this child currently receive <u>subsidy</u> assistance for childcare services? □ **Yes** □ **No**

If No, is child/family currently on subsidy waiting list? □ **Yes** □

No
Will extended day childcare services be required for this child? ☐ Yes ☐ No If Yes, check all that apply: ☐Before School Care ☐ After School Care ☐ Holiday Care ☐ Summer Care
Does family have alternative arrangements if extended day childcare services cannot be provided? ☐ Yes ☐ No If Yes, with whom:

FAMILY INCOME INFORMATION

☐*Weekly x 52 = Annual Income* ☐ *Bi-Weekly x 26 = Annual Income* ☐ ***Twice Monthly*** *x 24 = Annual Income* ☐ ***Monthly*** *x 12 = Annual Income*

Family Member	Amount	Per	x	Annual Income	Income Source
	$			$	
	$			$	
	$			$	
	$			$	
	Total Family Gross Annual Income			$	
Other Adult Household Members	Amount	Per	x	Annual Income	Income Source
	$			$	
	$			$	
	Total Household Gross Annual Income			$	

Family Income Verified by Reviewing Following:

____Pay Stubs ____Income Tax Form(s) _____W-2 Form(s) ____Child Support ____Statement from Employer ____Statement from DSS ____ Other

Based upon the above income verification, child is ____ELIGIBLE ____INELIGIBLE

Verification Completed by: ____

PARENT AND/OR GUARDIAN - PLEASE READ AND SIGN:

I understand that this is an application for services offered and does not constitute enrollment into any program. I certify that the information given on this application is true and accurate and all income has been reported. I understand that this information is being given for the receipt of federal and/or state funds; that officials may verify the information on this application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable federal and/or state laws.

The information on this form may be used only in the determination of eligibility for the Early Head Start program. I understand that I will be releasing information that will show that I am applying for my child to be considered for this program. Program administration may verify information on this form. I give up my rights to confidentiality for these purposes only.

I understand that if my child is selected to participate in the program, parent involvement will be critical to the success of my child. I/we will commit to participate as required by the program criteria.

I certify that I am the parent/guardian of the child for whom this application is being made.

_______________________________________ _____________________

Parent (Primary Caregiver) Signature (required) **Date**

_______________________________________ _____________________

Parent (Secondary Caregiver) Signature (if available) **Date**

_______________________________________ _____________________

Interviewer's Signature (required) **Date**

Verifications

q **Child's Birth Certificate**	q **Parent's Social Security Card**
q **Child's Social Security Card**	q **Proof of Income (W-2, current pay stub, child support, etc..)**
q **Child's Medicaid card or Private Insurance card**	q **AFDC/TANF (Letter stating award of money received), if applicable**
q **Child's Physical (within last 12 months)**	q **Food Stamp Card, if applicable**
q **Child's Immunization Record**	q **Verification of child's special needs, if applicable**