

HS_EHS_RAB_EHS-CCP (Fayette_Clinton_Highland_) Enrollment Form

Applicant's Last Name First Name Middle Date of Birth

Gender Race Hispanic/Latino City/State Born Spoken Language

Participant's Home Address –Street City State Zip Code County

Is child receiving services for: IEP/IFSP: **Y / N** Speech: **Y / N** Diagnosed disability: **Y / N**

Enrolled in Help Me Grow? **Y / N** Is parent/guardian pregnant? **Y / N** Due Date: _____

Applicant's doctor: _____ Applicant's dentist: _____

Current living arrangement: (Specify if you pay rent to the person you are living with)

Own _____ Rent _____ Motel _____ Shelter _____ Friends _____ Relative-Who? _____

Homeless _____ Other (Specify) _____

Do you receive food stamps/SNAP? Y / N Do you receive WIC? **Y / N** Does the household have reliable transportation? **Y / N**

Is parent/guardian currently working? Mom/Guardian #1: **FT PT N/A** Dad/Guardian #2: **FT PT N/A**

Is parent/guardian currently enrolled in school? Mom/Guardian #1: **FT PT N/A** Dad/Guardian #2: **FT PT N/A**

Is parent/guardian in the military or a veteran? Mom/Guardian #1: **ACTIVE VETERAN N/A** Dad/Guardian #2: **ACTIVE VETERAN N/A**

For Office Use Only

Date Accepted _____
 Date Of Entry _____
 EHS Homebased _____
 H.S.-Jeff. _____
 H.S.-W.C.H. _____
 H.S.-Cherry Hill _____
 RAB (EHS-CCP) _____
 Sunrise Sunset _____
 CCELC _____
 Income Verified:
 Points _____
 Under _____
 Over _____
 SSI/TANF/SNAP _____
 Homeless _____
 Foster _____
 Child's year in program
 1st 2nd 3rd

Names of Siblings in the home:	Birth Date	Race	Relationship to Child	Last Grade Completed		
1.						
2.						
3.						
4.						
Names of Parents/Guardian in the home:	Birth Date	Race	Relationship to Child	Last Grade Completed	Contact Information	Cell or Home
1.					Phone #:	
					Email:	
2.					Phone #:	
					Email:	

Does child currently have health insurance? **Y / N** Medical insurance name: _____

Do you currently receive cash benefits (TANF/OWF) from ODJFS? **Y / N** In the past 12 months? **Y / N**

How did you find out about Head Start? (Flyer/parent/friend/former H.S. child or sibling/referral/returnee/social media) _____

The following questions apply to biological parents and/or current household members:

Current or history of domestic violence? **Y / N** One or more parents currently or previously incarcerated? **Y / N**

Current or previous case with Children's Services? **Y / N** Current or history of substance abuse? **Y / N**

Does child have a deceased biological parent? **Y / N** Current or history of mental health? **Y / N**

I certify that this information is true. If any part is false, my participation in this agency's program may be terminated and may be subject to legal action. I understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent/Guardian Signature

Date

For Office Use Only:

Date Received _____
 By _____