HEAD START AND EARLY HEAD START APPLICATION

CATTARAUGUS AND WYOMING COUNTIES PROJECT HEAD START ▪ 101 SOUTH 19TH STREET ▪ OLEAN ▪ NY ▪ 14760

Please mail entire application to the above address ● For information please call our Administrative Office ● 716-373-2447

Visit our website to apply online www.headstartnetwork.com/wordpress

PREGNANT WOMAN: Check if application is for a pregnant woman □ If so, please list pregnant woman's name wherever it asks for child's information.

Child's last name	Child's first name	Date of Birth	□ Female □ Male
Child's Street address	City	Zip	County of residence
Child's mailing address (if different from above)	City	Zip	Primary Phone
Cell Phone/s	E-mail address		
Mother/Guardian's name	Date of Birth	Are you pregnant? □ YES □ NO Expected Due Date:_____ Have you received prenatal care? □ YES □NO	
Father/Guardian's name:	Date of Birth	How did you hear about our program?	

Please check your child's ethnicity **and** race. You are not required to answer this.
No child will be discriminated against due to race, sex, color, national origin, age or disability.

Ethnicity: (check one)
- □ Hispanic or Latino origin
- □ Non-Hispanic or Non-Latino origin

Race: (check one)
□ American Indian or Alaska Native □ Asian □ Black/African-American
□ White □ Biracial/Multi-racial □ Other_____

Does your child have an established medical diagnosis or disability? If yes, what is your child's disability?_____
Does your child have an IEP or an IFSP? □YES □NO
Name of Doctors, Specialists, Clinics, Agencies or School District working with my child or family: _____

Has your child attended an Early Head Start or Head Start program before? □ Yes □ No If yes, which one? □ Early Head Start □ Head Start

Specify program(s) and dates(s) of attendance Where?_____Dates:_____

Child resides with:
□ Both parents □ Mother only □ Father only □ Grandparents □ Guardians □ Foster Parents □ Step Parents □ Other _____

# of adults in household:_____# of children in household:_____ Ages of children: _____ , _____ , _____ , _____ , _____, _____ , _____

Does your child have health insurance? □ YES □ NO If yes, what type?_____--_____

Child's Medicaid Number:_____ Do you work? □ YES □ NO Do you go to school? □ YES □ NO

Check ALL sources of income you receive in your household:
□ Paycheck
□ Veterans Benefits
□ Social Security (Pension)
□ Unemployment Compensation
□ Public Assistance/TANF (this does not mean food stamps)
□ Public Assistance/Supplemental Security Income (SSI)
□ Child Support/Alimony
□ Adoption Subsidy
□ Other:_____

Total Gross Wages reported on last year's Federal Tax Return:$_____
OR
Total Gross Income (before deductions): $_____ □ Weekly □ Every 2 weeks □ Monthly □ Twice a month □ Annually

I understand that I need to submit proof of INCOME, CHILD'S BIRTHDATE and an IMMUNIZATION (SHOT) RECORD upon request.
I further understand that this application does not guarantee that my child will be in Early Head Start or Head Start.
I further understand that my child may be placed on a waiting list until an opening occurs. I certify that the information provided in this application is true and correct to the best of my knowledge. I understand that if I intentionally provide or attempt to provide false information that I and/or my child may no longer be eligible for enrollment in Cattaraugus & Wyoming Counties Project Head Start, subject to criminal prosecution.

PLEASE, review your application to make sure that all sections are complete.
All information will be kept confidential. Head Start complies with all statutes relating to nondiscrimination.

Parent/Guardian Signature _____ **Date** _____

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