WESTMORELAND COUNTY
HEAD START/EARLY HEAD START ENROLLMENT APPLICATION

Section 1: Eligible Child Information

Legal Name of Child (First, Middle, Last)	**Birthdate**	**Gender** ☐ Male ☐ Female	**Application Date:**

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

Race: ☐ White ☐ Black/African American ☐ Bi-racial/Multi-racial ☐ American Indian/Alaska Native ☐ Asian Other________________________

Child/Family's Primary Language: ☐ English ☐ Other: **English as Second Language:** ☐ Yes ☐ No

Does this child have Health Insurance? ☐ No ☐ Yes (Type) ____________________	**Does this child have Dental Insurance?** ☐ No ☐ Yes (Type) ____________________
Doctor's Name:	**Dentist's Name:**
Does this child have a health concern or disability/special needs? ☐ No ☐ Yes (Please specify) ____________________ ☐ Suspected (explain) ____________________	**Does this child have a current IEP or IFSP?** ☐ No ☐ Yes

Is there a Court Order limiting or restricting custody and/or access to the child? ☐ Yes ☐ No

** If there is a Court Order, please provide a certified, current copy of the order to Head Start **

Is this household: ☐ One Parent (Complete Section 2 with your information) ☐ Two Parent (Complete Sections 2 and 3)	**Household family size:** Total number of children: _______ Total number of adults: ________

Is your family experiencing homelessness (lack of a fixed, regular/adequate nighttime residence, Community Shelter) ☐ Yes ☐ No

Section 2: Parent/Guardian 1 - Information

□ **Parent (biological/adoptive/step)** □ **Grandparent** □ **Relative (other than grandparent)** □ **Foster**

Name (First/Middle/Last)	**Birthdate**	☐ Mother ☐ Father ☐ Other: ____________	**Resides in home?** ☐ Yes ☐ No

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

Race: ☐ White ☐ Black/African American ☐ Bi-racial/Multi-racial ☐ American Indian/Alaska Native ☐ Asian Other________________________

Primary phone #: **Alternate phone #:**

Email Address:

Street Address: **City:** **State:** **Zip:**

What school district does your family reside in?

Education Level (check highest completed):	**Are you currently working?**	**Are you a veteran of the United States military?**
☐ Less than High School graduate ☐ High School Graduate or GED ☐ Associate's Degree/Vocational/Some College ☐ Advanced Degree or Baccalaureate Degree **Are you currently in school/training?** ☐ No ☐ Yes ☐ Full-time ☐ Part-time	☐ Yes (check one below) ☐ Working Full Time (30+ hours each week) ☐ Working Part Time (Less than 30 hours each week) ☐ Seasonal ☐ No (check one below) ☐ Unemployed ☐ Looking for work ☐ Not looking for work ☐ Retired ☐ Disabled	☐ No ☐ Yes **Are you a member of the United States military on active duty?** ☐ No ☐ Yes

Do you currently have Health insurance for yourself? ☐ No ☐ Yes (type)

Section 3: Parent/Guardian 2 - Information ◻ N/A ◻ REFUSED ◻ DECEASED

◻ Parent (biological/adoptive/step) ◻ Grandparent ◻ Relative (other than grandparent) ◻ Foster

Name (First/Middle/Last)	**Birthdate**	☐ Mother ☐ Father ☐ Other: ____________	**Resides in home?** ☐ Yes ☐ No

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

Race: ☐ White ☐ Black/African American ☐ Bi-racial/Multi-racial ☐ American Indian/Alaska Native ☐ Asian Other____________

Primary phone number: **Email Address:**

Street Address: **City:** **State:** **Zip:**

Education Level (check highest completed):

☐ Less than High School graduate
☐ High School Graduate or GED
☐ Associate's Degree/Vocational/Some College
☐ Advanced Degree or Baccalaureate Degree

Are you currently in school/training?

☐ No
☐ Yes
- ☐ Full-time
- ☐ Part-time

Are you currently working?

☐ Yes (check one below)
- ☐ Working Full Time (35+ hours each week)
- ☐ Working Part Time (Less than 35 hours each week)

☐ No (check one below)
- ☐ Unemployed
  - ☐ Looking for work
  - ☐ Not looking for work
- ☐ Retired
- ☐ Disabled

Are you a member of the United States military on active duty?

☐ No
☐ Yes

Are you a veteran of the United States military?

☐ No
☐ Yes

Do you currently have Health insurance for yourself? ☐ No ☐ Yes (type)

Section 3: Program Options

☐ **Family needs year-round care**
☐ **Family needs part-year care (according to school district calendar)**
☐ **Family needs more than 6 hours of childcare per day**
☐ **Family is receiving CCIS**

Section 4: Other Household Members - include ALL children and adults in the household EXCEPT Parent/Guardian(s)

1. Name (First, Middle, Last)	**Birthdate**	**Gender** ☐ Male ☐ Female	**Relation to Eligible child:**

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

Race: ☐ White ☐ Black/African American ☐ Bi-racial/Multi-racial ☐ American Indian/Alaska Native ☐ Asian Other____________

Health Insurance: ☐ No ☐ Yes (type)

2. Name (First, Middle, Last)	**Birthdate**	**Gender** ☐ Male ☐ Female	**Relation to Eligible child:**

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

Race: ☐ White ☐ Black/African American ☐ Bi-racial/Multi-racial ☐ American Indian/Alaska Native ☐ Asian Other____________

Health Insurance: ☐ No ☐ Yes (type)

3. Name (First, Middle, Last)	**Birthdate**	**Gender** ☐ Male ☐ Female	**Relation to Eligible child:**

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

Race: ☐ White ☐ Black/African American ☐ Bi-racial/Multi-racial ☐ American Indian/Alaska Native ☐ Asian Other____________

Health Insurance: ☐ No ☐ Yes (type)

Does anyone in the household have a disability? ☐ No ☐ Yes (explain)

*Continue to page 4 to list any additional household members

Section 5: Income Eligibility

How is my family eligible?

Someone in the household is:

- ☐ Receiving SSI
- ☐ Receiving Cash Benefits (TANF)
- ☐ Child Applying is a Foster Child
- ☐ Experiencing homelessness
- ☐ Income eligible ⇨

Size of Family	Annual Income (100%)	130%	Size of Family	Annual Income (100%)	130%
1	$12,060	$15,678	**5**	$28,780	$37,414
2	$16,240	$21,112	**6**	$32,960	$42,848
3	$20,420	$26,546	**7**	$37,140	$48,282
4	$24,600	$31,980	**8**	$41,320	$53,716

Section 6: Household Monthly Family Income

Employment: $ ______________________________ /month

Social Security Disability (SSD): $ ______________________________ /month

Child Support: $ ______________________________ /month

Spousal Support/Alimony: $ ______________________________ /month

Unemployment: $ ______________________________ /month

Other: $ ______________________________ /month

*** PROOF OF INCOME (12 MONTHS PRIOR TO APPLICATION DATE), PROOF OF CASH ASSISTANCE, SSI DOCUMENTATION OR FOSTER PLACEMENT LETTER MUST BE SUBMITTED ALONG WITH THE APPLICATION TO BE CONSIDERED FOR THE PROGRAM ***

(ANY AND ALL DOCUMENTS SENT WILL BE KEPT CONFIDENTIAL)

Is your family receiving any of these services or experiencing any of the following?

- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ WIC
- ☐ Energy Assistance
- ☐ Medical Assistance
- ☐ Involvement with Westmoreland County Children's Bureau
  - ☐ Not currently, but have been in the past
- ☐ Mental Health Services
- ☐ Life skills/Family Preservation
- ☐ Westmoreland Case Management (WCSI)
- ☐ Intermediate Unit
- ☐ Early Intervention
- ☐ Food Banks

- ☐ Domestic Violence
- ☐ Currently Incarcerated Parent
- ☐ Death of an Immediate family member
- ☐ Parental Drug/Alcohol Abuse
- ☐ Teen Parent
- ☐ Disaster/Tragedy/Severe trauma in family
- ☐ Military Deployment
- ☐ Housing and/or utility issues
- ☐ Lack of enough food/clothing
- ☐ Chronic health problems

How did your family learn about Head Start? ☐ Flyer ☐ Friend or Relative ☐ Enrolled before ☐ Online ☐Website ☐ Community Event ☐ Magazine, Clipper, Phonebook ☐ Advertisement ☐ Pizza box/hoagie ☐ Elementary school ☐ Agency Referral ______________________________

☐Other______________________________

I declare under penalty of perjury and the laws of the state of Pennsylvania that the information and income contained herein is true and correct to the best of my knowledge. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also 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.

Primary Caregiver Signature: ______________________________

Secondary Caregiver Signature: ______________________________
(If present)

Date: ______________________________

Staff Signature: ______________________________

Date: ______________________________

Other Household Members (Continued)

4. Name (First, Middle, Last)	**Birthdate**	**Gender** ☐ Male ☐ Female	**Relation to Eligible child:**

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

Race: ☐ White ☐ Black/African American ☐ Bi-racial/Multi-racial ☐ American Indian/Alaska Native ☐ Asian Other_______________

Health Insurance: ☐ No ☐ Yes (type)

5. Name (First, Middle, Last)	**Birthdate**	**Gender** ☐ Male ☐ Female	**Relation to Eligible child:**

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Health Insurance: ☐ No ☐ Yes (type)

6. Name (First, Middle, Last)	**Birthdate**	**Gender** ☐ Male ☐ Female	**Relation to Eligible child:**

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

Race: ☐ White ☐ Black/African American ☐ Bi-racial/Multi-racial ☐ American Indian/Alaska Native ☐ Asian Other_______________

Health Insurance: ☐ No ☐ Yes (type)

Central Office:
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Greensburg, PA 15601
(724)836-0099
Fax: (724)836-1346
www.shchildservices.org

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Greensburg, PA 15601
c/o Head Start
(724)834-1260 ext. 121
Fax: (724)838-9563
www.westmorelandca.org