Head Start of Washington County, Inc.

ELIGIBILITY AND SELECTION FORM

CHILD INFORMATION

Child's Name _____

Date of Birth _____ ☐ Male ☐ Female

Address _____
STREET STATE ZIP

Mailing address if different than above

_____
STREET STATE ZIP

Home Phone Number ___(_____)_____

If no home number, nearest contact number ___(_____)_____

Number of people living in household supported by parent's income? Children_____ Adults_____

Child's Primary Language _____ Child's Race _____

Child lives with: ☐ Mother ☐ Father ☐ Both Parents
☐ Foster Parent(s) ☐ Guardian

Does Child have Medical Insurance? ☐ Yes ☐ No

Does child have any special needs? ☐ Yes ☐ No

If yes please list _____

Has child been Diagnosed by a Professional? ☐ Yes ☐ No (Documentation Required)

Does your child have an I.E.P./ I.F.S.P? ☐ Yes ☐ No

PLEASE CHOOSE ALL THAT APPLY: (PLACEMENT DEPENDS ON AVAILABILITY)

I would be willing to accept the following program options for my child:

☐ Part Day Classes

☐ Home Based Program

☐ Full Day Classes *(must have POC vouchers from DSS)*

Do you receive Child Care Vouchers? ☐ Yes ☐ No

Can you provide daily transportation for your child if necessary? ☐ Yes ☐ No

Do you have another child(ren) applying for or enrolled in Early Head Start or Head Start ?

If Yes, what is the child(ren)s name(s):

_____

FAMILY INFORMATION

Female Parent /Guardian _____
IF LIVING IN THE HOME

Date of Birth _____

Parent's Primary Language _____ Parent's Race _____

Is Female Parent/Guardian under age 20? ☐ Yes ☐ No

Do you have a Diploma or GED? ☐ Yes ☐ No

Are you currently Pregnant? ☐ Yes ☐ No

Is English your second language? ☐ Yes ☐ No

Email Address _____@_____

Work Phone Number ___(_____) _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Male Parent /Guardian _____
IF LIVING IN THE HOME

Date of Birth _____

Parent's Primary Language _____ Parent's Race _____

Is Male Parent/Guardian under age 20? ☐ Yes ☐ No

Do you have a Diploma or GED? ☐ Yes ☐ No

Is English your second language? ☐ Yes ☐ No

Email Address _____@_____

Work Phone Number ___(_____) _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Is child currently homeless, living in a shelter or halfway house? ☐ Yes ☐ No

Are three or more children under age 5 living in household? ☐ Yes ☐ No

Does family receive Food Stamp Assistance? *(Eligibility letter required)* ☐ Yes ☐ No

Does family receive SSI Benefits? ☐ Yes ☐ No

Is child receiving services from another agency?

☐ Judy Center ☐ Birth –5 ☐ Healthy Families ☐ Family Center

How did you hear about Head Start? _____

Parent/Guardian Signature _____ Date _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Mail or Return to:

Head Start of Washington County, Inc., 131 West North Avenue, Hagerstown, MD 21740

(301) 797-5231

Please note that this application is valid for one year. You must reapply if not accepted

FOR OFFICE USE ONLY

_____ _____
Family Number Ranking Points

FOR REFERRAL AGENCY ONLY

FAMILY INCOME

EMPLOYMENT

Male Parent/Guardian (IF LIVING IN HOME)

Gross Income (BEFORE TAXES) $_____

Employer's Name _____

Employer's Phone Number_(____)_____

☐ Full Time No. of Hours _____
☐ Part Time No. of Hours _____

Pay Period ☐ Weekly ☐ Bi-Weekly ☐ Twice a Month ☐ Monthly ☐ Annually

Year Round ☐ Yes ☐ No
Seasonal ☐ Yes ☐ No

PLEASE INCLUDE A COPY OF YOUR W-2 FORM OR 1040

Complete if there is a second place of employment

Gross Income (BEFORE TAXES) $_____

Employer's Name _____

Employer's Phone Number_(____)_____

☐ Full Time No. of Hours _____
☐ Part Time No. of Hours _____

Pay Period ☐ Weekly ☐ Bi-Weekly ☐ Twice a Month ☐ Monthly ☐ Annually

Year Round ☐ Yes ☐ No
Seasonal ☐ Yes ☐ No

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EMPLOYMENT

Female Parent/Guardian (IF LIVING IN HOME)

Gross Income (BEFORE TAXES) $_____

Employer's Name _____

Employer's Phone Number_(____)_____

☐ Full Time No. of Hours _____
☐ Part Time No. of Hours _____

Pay Period ☐ Weekly ☐ Bi-Weekly ☐ Twice a Month ☐ Monthly ☐ Annually

Year Round ☐ Yes ☐ No
Seasonal ☐ Yes ☐ No

PLEASE INCLUDE A COPY OF YOUR W-2 FORM OR 1040

Complete if there is a second place of employment

Gross Income (BEFORE TAXES) $_____

Employer's Name _____

Employer's Phone Number_(____)_____

☐ Full Time No. of Hours _____
☐ Part Time No. of Hours _____

Pay Period ☐ Weekly ☐ Bi-Weekly ☐ Twice a Month ☐ Monthly ☐ Annually

Year Round ☐ Yes ☐ No
Seasonal ☐ Yes ☐ No

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OTHER HOUSEHOLD INCOME

IF APPLICABLE COMPLETE INFORMATION FOR ALL THAT APPLY TO YOUR HOUSEHOLD

SOURCE	AMOUNT
TANF (TCA) (INCLUDE CERTIFICATION LETTER)	$_____
Social Security/Pension (INCLUDE LETTER OF ELIGIBILITY)	$_____
SSI Benefits (INCLUDE LETTER OF ELIGIBILITY)	$_____
Child Support ☐ Weekly ☐ Biweekly ☐ Monthly (INCLUDE COPY OF CHECK OR BANK STATEMENT)	$_____
Unemployment ☐ Weekly ☐ Biweekly (INCLUDE COPY OF UNEMPLOYMENT CHECK OR CHECK STUB W / START DATE)	$_____
Foster Care Subsidy (INCLUDE COPY OF AWARD LETTER)	$_____
Other: Specify (INCLUDE LETTER OF SUPPORTING DOCUMENTATION)	$_____

☐ NO INCOME

Please Sign after Reading Below

_____

SIGNATURE DATE

I understand that this form will be used to receive benefits under the Federal Head Start Program. Providing knowingly false information may be a criminal violation under Federal Law. By signing this form, I certify and attest that to the best of my knowledge, the information provided on this form is true and accurate.

NOTE: ALL INCOME MUST BE VERIFIED. IF YOU RECEIVE FOOD STAMPS, A COPY OF YOUR CERTIFICATION LETTER MUST BE INCLUDED.

☐ In-Person Interview Date & Staff Initials _____

☐ Phone Interview Date & Staff Initials _____

Reason:_____