Head Start of Washington County, Inc.

EARLY HEAD START EXPECTANT MOTHER ELIGIBILITY AND SELECTION FORM

Name _____ Date of Birth _____

Address _____
STREET CITY STATE ZIP

Mailing address if different than above

_____
STREET CITY STATE ZIP

Race /Ethnicity _____ Home Phone (_____)_____

Primary Language _____ Work Phone (_____)_____

Expected Delivery Date _____ Message Phone (_____)_____

MARITAL STATUS:

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Are you expecting to have a multiple birth (twins, triplets, etc.)? ☐ Yes ☐ No

Does your family receive SNAP ? ☐ Yes ☐ No

Does family receive SSI Benefits? ☐ Yes ☐ No

Are you currently homeless or in a shelter? ☐ Yes ☐ No

Are you under 20 years of age? ☐ Yes ☐ No

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

Are you currently attending school? ☐ Yes ☐ No

If yes, check one of the following: ☐ Middle School ☐ High School ☐ College ☐ Other

Name of School attending:_____

Do you have a child applying for or enrolled in Early Head Start or Head Start? ☐ Yes ☐ No

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

Do you have Medical Insurance? ☐ Yes ☐ No

Medical Card Number:_____

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

Do you plan to enroll your child in the Early Head Start program when it is born?

☐ YES ☐ NO —If YES, which program choice:

- ☐ Home Based Program
- ☐ Extended Day (6 hrs)
- ☐ Full Day Classes -Elgin Station (requires Child Care Scholarship)

Do you currently have a Child Care Schlarship? ☐ Yes ☐ No

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

Number of people living in household?

_____Adults _____Children (include unborn child)

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

How did you hear about Head Start?

_____

Does unborn child's father live in household? ☐ Yes ☐ No

If Yes, please complete the following:

Male Parent /Guardian

_____

Date of Birth _____

Parent's Primary Language _____

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

Does he have a Diploma or GED? ☐ Yes ☐ No

Is English his second language? ☐ Yes ☐ No

_____
Signature Date

★ **PLEASE COMPLETE BOTH SIDES OF THIS FORM** ★

Mail or Return to:

Head Start of Washington County, Inc.
837 Spruce Street
Hagerstown, MD 21740
(301) 733-4640

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
☐ Monthly ☐ Annually
☐ Twice a Month

Year Round ☐ Yes ☐ No
Seasonal ☐ Yes ☐ No

ATTACH A COPY OF YOUR
W-2 (Wage & Tax Form)
OR
1040 (IRS Form)

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
☐ Monthly ☐ Annually
☐ Twice a Month

Year Round ☐ Yes ☐ No
Seasonal ☐ Yes ☐ No

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OTHER HOSEHOLD INCOME

IF APPLICABLE COMPLETE INFORMATION FOR ALL THAT APPLY TO YOUR HOUSEHOLD

Check Box if you receive	SOURCEOF INCOME	AMOUNT RECEIVE
☐	TANF (TCA) Cash Assistance (ATTACH COPY OF BENEFITS SUMMARY LETTER)	$ _____
☐	Social Security | Disability (ATTACH COPY OF BENEFITS SUMMARY LETTER)	$ _____
☐	SSI Benefits (ATTACH COPY OF BENEFITS SUMMARY LETTER)	$ _____
☐	Unemployment Benefits ☐ Weekly ☐ Bi-Weekley (ATTACH COPY OF UNEMPLOYMENT CHECK OR CHECK STUB W / START DATE)	$ _____
☐	Foster Care Subsidy (ATTACH COPY OF SUBSIDY BENEFITS LETTER)	$ _____
☐	Other: _____	$ _____
☐	SNAP - SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (ATTACH COPY OF SNAP BENEFITS DOCUMENTATION)	
☐	NO INCOME	

All income items checked the items in Red Text must this application to be accepted.
AND !! All income and benefits must be verified!!

Complete if there is a second place of 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
☐ Monthly ☐ Annually
☐ Twice a Month

Year Round ☐ Yes ☐ No
Seasonal ☐ Yes ☐ No

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Complete if there is a second place of 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
☐ Monthly ☐ Annually
☐ Twice a Month

Year Round ☐ Yes ☐ No
Seasonal ☐ Yes ☐ No

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PLEASE SIGN BELOW AFTER READING

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

_____ _____
Signature Date

☐ In-Person Interview Date and Staff Initials ____

☐ Phone Interview Date and Staff Initials _____

Reason: _____