Head Start of Washington County, Inc.

ELIGIBILITY AND SELECTION FORM

CHILD INFORMATION

Child's Name _____

Date of Birth _____ ☐ Male ☐ Female

Address _____
(Street Address ; City ; State ; Zip)

Mailing address if different than above

_____
(Street Address ; City ; State ; Zip)

Phone Number (____) _____ Who's phone is this? _____

If you have no phone, list number you can be reached at or nearest relatives phone who can reach you.

Phone Number (____) _____ Who's phone is this? _____

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 Special Needs? ☐ Yes ☐ No

If YES to Special Needs, please list _____

Has Child been diagnosed by a Professional? ☐ Yes ☐ No *(DOCUMENTION IS REQUIRED)*

Does Child have I.E.P or 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: (check all that apply)

☐ Extended Day (6 hrs)

☐ Full-Day | Full-Year (hours vary)
REQUIRES CHILD CARE SCHOLARSHIP / VOUCHER

☐ Home Based Program
(home visits from teacher & group socializations)

Do you receive a Child Care Scholarship/ Voucher? ☐ Yes ☐ No

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

Do you have other children applying for or already enrolled in
Early Head Start or Head Start? ☐ Yes ☐ No

If **YES**, Children's Names: _____

FAMILY INFORMATION

Female Parent/Guardian Name (If living in the home) _____

Date of Birth _____

Parent's Primary Language _____ Parent's Race _____

Is Female Parent/Guardian under 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 Name (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 SNAP (Supplemental Nutrition Assistance Program)? ☐ Yes ☐ No

Does family receive SSI Benefits? ☐ Yes ☐ No

Is child receiving services from another agency ? (Below)
☐ Judy Center ☐ Birth-K ☐ Healthy Families ☐ Family Center ☐ WIC

How did you hear about Head Start? _____

_____ _____
Signature Date

FOR OFFICE USE ONLY

_____
Ranking Points

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

Return to address below or email to mjones@headstartwashco.org

Head Start of Washington County, Inc., 837 Spruce Street Hagerstown, MD 21740

Phone : (301) 733-4640 Ext. 110

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

FOR REFERRAL AGENCY ONLY

★ FAMILY INCOME ★

EMPLOYMENT

MALE Parent/Guardian (IF LIVING IN HOME)

GROSS INCOME $ _____

(GROSS INCOME IS AMOUNT RECEIVED BEFORE TAXES ARE TAKEN OUT)

PAY PERIOD *(HOW OFTEN DO YOU RECEIVE THIS AMOUNT)*

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

YOU WORK ☐ Full Time - No. of Hours _____
☐ Part Time - No. of Hours _____

Year Round ☐ Yes ☐ No
Seasonal ☐ Yes ☐ No

Employer's Name: _____
Employer's Phone Number: (____) _____

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

COMPLETE IF THERE IS A SECOND PLACE OF EMPLOYMENT

GROSS INCOME $ _____

(GROSS INCOME IS AMOUNT RECEIVED BEFORE TAXES ARE TAKEN OUT)

PAY PERIOD *(HOW OFTEN DO YOU RECEIVE THIS AMOUNT)*

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

YOU WORK ☐ Full Time - No. of Hours _____
☐ Part Time - No. of Hours _____

Year Round ☐ Yes ☐ No
Seasonal ☐ Yes ☐ No

Employer's Name: _____
Employer's Phone Number: (____) _____

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

EMPLOYMENT

FEMALE Parent/Guardian (IF LIVING IN HOME)

GROSS INCOME $ _____

(GROSS INCOME IS AMOUNT RECEIVED BEFORE TAXES ARE TAKEN OUT)

PAY PERIOD *(HOW OFTEN DO YOU RECEIVE THIS AMOUNT)*

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

YOU WORK ☐ Full Time - No. of Hours _____
☐ Part Time - No. of Hours _____

Year Round ☐ Yes ☐ No
Seasonal ☐ Yes ☐ No

Employer's Name: _____
Employer's Phone Number: (____) _____

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

COMPLETE IF THERE IS A SECOND PLACE OF EMPLOYMENT

GROSS INCOME $ _____

(GROSS INCOME IS AMOUNT RECEIVED BEFORE TAXES ARE TAKEN OUT)

PAY PERIOD *(HOW OFTEN DO YOU RECEIVE THIS AMOUNT)*

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

YOU WORK ☐ Full Time - No. of Hours _____
☐ Part Time - No. of Hours _____

Year Round ☐ Yes ☐ No
Seasonal ☐ Yes ☐ No

Employer's Name: _____
Employer's Phone Number: (____) _____

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

OTHER HOUSEHOLD INCOME

IF APPLICABLE COMPLETE INFORMATION FOR ALL THAT APPLY TO YOUR HOUSEHOLD

check box if you receive	SOURCE OF 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-Weekly (ATTACH COPY OF UNEMPLOYMENT CHECK OR CHECK STUB W / START DATE)	$ _____
☐	Foster Care Subsidy (ATTACH COPY OF SUBSIDY BENEFITS LETTER)	$ _____
☐	Other: _____ (ATTACH COPY OF LETTER OF SUPPORTING DOCUMENTATION)	$ _____
☐	SNAP - SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (ATTACH COPY OF SNAP BENEFITS DOCUMENTATION)	

☐ NO INCOME

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

PLEASE SIGN BELOW AFTER READING STATEMENT

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.

_____ _____
Parent/Guardian Signature Date

OFFICE ONLY

☐ In-Person Interview Date_____ Employee Initials_____
☐ Phone Interview Date_____ Employee Initials_____
Reason:_____