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   *(DOCUMENTATION 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?

Parent/Guardian Signature

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

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)*	$
Child Support Weekly Bi-Weekly Monthly *(ATTACH COPY OF COURT ORDERED BENEFITS 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 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

OFFICE ONLY

☐ In-Person Interview Date_____ Employee Initials_____
☐ Phone Interview Date_____ Employee Initials_____

Reason:_____

You must SAVE the file under Childs Name (Example: Stephen Smith)