

Pickaway County Head Start
ENROLLMENT APPLICATION
145 East Corwin Street • Circleville, Ohio 43113
(740) 474-7411

It is the responsibility of Head Start personnel to maintain confidentiality and protect the privacy of Head Start children and families. Head Start parents also have the right to review child and family records, and to request an explanation for information in those records, as well as how it is used.

Center Attending: []Circleville []Ashville []Westfall []Homebase
Start Date _____
Classroom _____ AM ___ PM ___



Child's Name _____

Birth Date _____ Sex M _____ F _____

(e) Child will attend Kindergarten Fall of 20 _____ Age _____ S.S.N. _____

Parent(s) or Guardian(s) _____

Street, Rural Route or Box No. _____

City _____ Zip Code _____ County _____

Phone _____

(i) List all children (under age 21 years) in the home:

Table with 4 columns: Name, Date of Birth, Name, Date of Birth. Three rows of blank lines for entry.

Total Number Living In Household _____ (c) (f) Single Parent Household? Yes _____ No _____

Is this a Foster Child Yes _____ No _____

(h) Do you feel your child has enough opportunities to play with other children? Yes _____ No _____

Is the child developing (walking, talking, playing, etc.) as fast as other children his/her age?

Yes _____ No _____ Explain: _____

(i) List allergies (food, animals, etc.) or medical problems _____

(f) (d) Explain the need for Head Start services for your family _____

(j) Has this child been in Head Start before? Yes _____ No _____ Have you had other children in Head Start before? Yes _____ No _____

(g) Do you have any special concerns about your child's development or behavior?

Yes _____ No _____ Explain: _____

TRANSPORTATION SERVICES

Do you wish Head Start to provide transportation to and from classes daily? Yes _____ No _____

If no, who will be transporting? _____

If Head Start is to transport please fill in the following information:

Pick up address: _____ Name _____ Phone # _____

Drop off address: _____ Name _____ Phone# _____

Signature: _____ Date: _____

HEALTH PROVIDER INFORMATION

Is your family receiving TANF: Yes _____ No _____
Is your child on Medicaid/EPSDT
Healthy Start/Healthy Families? Yes _____ No _____ (attach a copy)
Is Parent(s)/Guardian(s) on Medicaid/EPSDT Yes _____ No _____
Is your family receiving food stamps? Yes _____ No _____
Is your family receiving WIC services? Yes _____ No _____
Is your child covered for dental services
under an employee health care plan? Yes _____ No _____ (attach a copy)
I have received the Head Start HIPAA document Yes _____ No _____

Where will your child be staying while not at Head Start?

1.) Daycare Center _____ 2.) Friend/Relative in my home _____
3.) Family Child Care (Home) _____ 4.) Public School Pre-Kindergarten Program _____
5.) Other _____

Do you receive any childcare subsidy (voucher) for this child, whether care is provided by Head Start or another provider? Yes _____ No _____

EDUCATION:

1.) Bachelor's Degree or Higher Mom _____ Dad _____
2.) Some College Mom _____ Dad _____
3.) Vocational School Mom _____ Dad _____
4.) High School Graduate or GED Mom _____ Dad _____
5.) Last grade attended? Mom _____ Dad _____

JOB TRAINING/EDUCATION STATUS

Are you currently in job training or attending school? Yes _____ No _____

All persons making application to Head Start must provide one of the following documents as proof of Gross Family Income

Documents **attached** for verification:

- Income Tax Form 1040A or 1040
- Social Security
- W-2 Form
- Unemployment Compensation
- SSI
- Check Stub
- TANF (statement from caseworker)
- OTHER

I believe that the income and other preceding information is true to the best of my knowledge.

Signature of Parent(s)/Guardian(s) Date

(b) Where did you obtain this application? _____

For Office Use Only

_____ Age
_____ Over
_____ Under

Screened by _____

Income Amount (choose one) \$ _____ Yearly \$ _____ Monthly