# **ENROLLMENT APPLICATION**

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#### SOUTHEASTERN COMMUNITY ACTION PARTNERSHIP, INC. EARLY HEAD START PROGRAM

Applicant's Legal Name	e:												Date o	f Birth	:	
Center Name:	(Last)					rst) (Middle) Class Age: 2				(00/00/0000) For Program Year:						
				PRIMA	RY AD	шт	- PAR	=NT/G	110	RD	ΙΔΝ					
Last:			<u> </u>	First:							dle In	itial:	Prefer	red:		Suffix:
Social Security Number:			Date	e of Birth	:						S	ngle or Two Parent Home: Gender:			Gender: M F	
Lives with Family?	Provides	s Financia	l Sup	port?	Hial	nest G	rade Co	mplete	d:		Em	plovme	nt Statu	IS:	In T	raining/School:
Yes No			lo		5									-		Yes No
Race: (List all that apply)		Nationa	ality:	Eth	nicity:	Rel	ationshi	ip to A	ppli	cant		<b>Teen</b> Yes	Teen Parent: Former HS Parent:			
Primary Language Spoker	n In Hor	ne:					Primary	Langu	iage	):			En	glish P	roficien	cy:
🗆 English 🗆 Spanish 🛛	□ Othe	r (List)									C	) = None	• <b>1</b> = Po	oor <b>2</b> =	Modera	te 3 = Proficient
					Lľ	VING		ESS								
Living (Physical) Address	;															
City							State:	<u> </u>	7:			6		Pla	don Drur	nswick, Columbus
City							State:		Zip			60	unty:			tland, Robeson
Mailing Address: (If Differe	ent)															
City									Sta	te:				Z	ip:	
			P	HONE		IRS A					SSE	5				
Туре Р				Prin	nary	ry Phone Number					Email Address				ess	
H = Home W = Work C	C = Cell	M = Mess	age	Yes	No											
H = Home W = Work C	C = Cell	M = Mess	age	Yes	No											
						GE	NERAL	-								
Parental Status: One	Two	Primary	Lang	uage at ⊦	lome:						1	Homeles	ss: Ye	s No		
Number in Family:		Number				By Age: 0-3 4-5						Number in Household:				
		Humber				_	E SUPF				<u> </u>	unioci	IIIIIous			
				.,												
TANF Status: Yes N	No For		SSI:		-	WIC: Yes No SNAP:										
	1						I INCO	ME D	00	UM			)			
Family Member	Date		mplo me S	ource		oss ount	x	Per	•	=		Annual Amount		Desc		Verification
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Calculation	for Ann					-	Total F Description	•		me	\$			Varifiaa	tion Cod	
Twice a month x 24 =Annual		Weekly x 5		anual	PE	N – Pen		SS – Soc		ecurit	tv	CS – Cheo			loyer Lette	
Monthly x 12 = Annual		Bi-weekly x					pplementa				,					oster No Income
			5	ECONE	DARY A	DUL.	<b>T – PA</b>	RENT	'/GL					<u> </u>		
Last:				First:						Mic	dle In	itial:	Prefer	red:		Suffix:
Social Security Number: Date of E				Birth:						S	Single or Two Parent Home: Gender:					
Lives with Family?	Pro	vides Fina	incial	Support	? Hi	ghest	Grade C	omple	ted	:	Em	ployme	nt Statu	IS:	In T	M F raining/School:
Yes No		Yes	No													
Race: (List all that apply)	Nati	onality:	E	thnicity:	Rel	ations	hip to A	pplica	nt:			Teen Parent:         Former HS Parent:           Yes         No         Yes         No				
	Inguage(s) Spoken (Check all that apply):       Primary Language:       English Proficiency:         □ English □ Other (List):       O = None 1 = Poor 2 = Moderate 3 = Well							-								
		or (Liot).										0 -	10110	1 001	2 - WIC	

# ENROLLMENT APPLICATION

Page 2 of 4

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SOUTHEASTERN COMMUN	IITY A	CTION	PART	NERSHI	P, INC.
	EARI	LY HEA	D STA	RT PRO	GRAM

Appl	Applicant's Legal Name: Date of Birth:											
		(Last	t) (First)		(Midd	le)			(00/0	00/0000)		
	OTHER CHILDREN IN HOME (USE SEPARATE SHEET IF NEEDED)											
	First and Last Name of Children In Home Other Than Applicant	Date of Birth	Social Security #	Sex		onship to Ilicant	Participation Status	Race	Primary Language	English Proficiency		
				ΜF								
				ΜF								
				ΜF								
				ΜF								
				ΜF								
			APPLICANT	INFOR	MATION	1						
Last		First	Mi	ddle Nam	ie		Preferred	d:	Suffix:			
Socia	I Security Number:	Date of B	irth:			Is this a	foster child?:	: Yes No	Gender:	MF		
Race:	: (List all that apply)	N	ationality: (Country)		Ethnicit	y:		Custody:	Yes No			
-	uage(s) Spoken (Check all that a	ipply):		Prima	ry Langua	age:		inglish Profic	•			
	English  Spanish  Other							Poor 2 = Mo		Proficient		
Prima	ary Adult's Name:					now is Ap	olicant Relate	u to Primary	Auuit:			
Birth		Certified Birth										
	HEALTH CARE NEED	S: DISABILIT	IES, HEALTH, MENTAL	HEALTH,	NUTRITIC	N, FAMILY	CRISIS, AND I	REFERRAL IN	FORMATIO	N		
	ny child with health care needs, su ached to the application. The med								nedical action	on plan shall		
Is the	re a medical action plan attached?	Yes No										
List ar	ny allergies and the symptoms and	l type of respo	onse required for allergi	c reaction	S							
List ar	ny health care needs or concerns,	symptoms of	and type of response fo	or these h	ealth care	needs or c	oncerns					
List ar	ny particular fears or unique behav	vior characteris	stics the child has:									
	ny types of mediaction taken for he	alth care peop										
	ny types of medication taken for he											
Share	any other information that has a c	lirect bearing of	on assuring safe medic	ai treatme	ent for you	r child:						
ls chil	d receiving therapy? Yes No	Suspect	ed (If yes, give dia	gnosis an	d list the th	nerapy serv	ice provider: [	Diagnosis:				
Servi	Service Provider:If suspected, list concern(s):											
	Was child referred to program by a Child Welfare Agency or any other professional/agency? Yes No (If yes, list name of professional/agency											
Any specific family need or crisis? Yes No (If yes, describe.) CONTACTS (PLEASE COMPLETE ALL INFORMATION)												
	Name:	CONTACI	S (PLEASE COI					Dalati	onchin to f	Child		
-				Phone		Ph	one Number	Relati	onship to (	onnu.		
ct #1	Address:			ΗWC		( )			mergency	Contact		
Contact	City:				СΜР	( )			elease To			
ပိ	State:	Zip:		нмс	ΜΡ	( )		Phone	e Note:			

# ENROLLMENT APPLICATON Page 3 of 4

#### SOUTHEASTERN COMMUNITY ACTION PARTNERSHIP, INC.. EARLY HEAD START PROGRAM

Name:       Phone Type       Phone Number       Relationship to Child:         Address:       I       H       W C       M       P       ()       Image: Control         City:       I       H       W C       M       P       ()       Image: Control       Relationship to Child:         State:       Zip:       H       W C       M       P       ()       Release To         Marrie:       Phone Type       Phone Number       Relationship to Child:       Address:       Image: Phone Type       Phone Number       Relationship to Child:         Address:       Zip:       H       W C       M       P       ()       Image: Relationship to Child:         Address:       Zip:       H       W C       M       P       ()       Image: Relationship to Child:         Address:       Zip:       H       W C       M       P       ()       Image: Relationship to Child:         Address:       Zip:       H       W C       M       ()       Image: Relationship to Child:         Address:       Zip:       Phone Number       Relationship to Child:       Address:       City:       State:       Zip:       Phone Note:         Doctor Name:       Address: <t< th=""><th>Appli</th><th colspan="13">Applicant's Legal Name: Date of Birth: (Just) (First) (Middle) Date of Birth: (00/00/0000)</th></t<>	Appli	Applicant's Legal Name: Date of Birth: (Just) (First) (Middle) Date of Birth: (00/00/0000)												
Address:       H       H       C       P<		Name:	(	Last)	(First	)			,	Dhono Numbo		Relatio		
Years:       Phone Type       Phone Number       Relationship to Child:         Address:       Phone Type       Phone Number       Relationship to Child:         City:       H W C M P       ()       Emergency Conti         State:       Zip:       H W C M P       ()       Relationship to Child:         Mame:       Phone Type       Phone Number       Relationship to Child:         Address:       Zip:       H W C M P       ()       Emergency Conti         Address:       Phone Type       Phone Number       Relationship to Child:         City:       H W C M P       ()       Emergency Conti         Address:       Zip:       H W C M P       ()       Phone Note:         Doctor Name:       Address:       City:       State:       Zip:       Phone:         Interret Hospital       Address	: #2													
Years:       Phone Type       Phone Number       Relationship to Child:         Address:       Phone Type       Phone Number       Relationship to Child:         City:       H W C M P       ()       Emergency Conti         State:       Zip:       H W C M P       ()       Relationship to Child:         Mame:       Phone Type       Phone Number       Relationship to Child:         Address:       Zip:       H W C M P       ()       Emergency Conti         Address:       Phone Type       Phone Number       Relationship to Child:         City:       H W C M P       ()       Emergency Conti         Address:       Zip:       H W C M P       ()       Phone Note:         Doctor Name:       Address:       City:       State:       Zip:       Phone:         Interret Hospital       Address	tact													
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Address:       Index runder       Index runder       Index runder         Address:       H W C M P ()       Image: Relationship to Child         State:       Zip:       H W C M P ()       Image: Relationship to Child         Mame:       Phone Type       Phone Number       Relationship to Child         Address:       Image: Lip:       H W C M P ()       Image: Relationship to Child         Itate:       Zip:       H W C M P ()       Image: Relationship to Child         Itate:       Zip:       H W C M P ()       Image: Relationship to Child         Itate:       Zip:       H W C M P ()       Image: Release To         Itate:       Zip:       H W C M P ()       Image: Release To         Doctor Name:       Address:       City:       State:       Zip:       Phone: ()         Doctor Name:       Address:       City:       State:       Zip:       Phone: ()       ()         Preferred Hospital       Address:       City:       State:       Zip:       Phone: ()       ()         Income Status:       On Medicaid       Not Eligible       Medicaid Number:       Prone: ()       ()         Primary Health Coverage:       Insurance CompanylNumber:       Insurance CompanylNumber:       Phone: ()       ()	•			-4	,									
Image:       Phone Type       Phone Number       Relationship to Child:         Address:       Phone Type       Phone Number       Relationship to Child:         City:       It       H       W       M       P       []       Image part of the time time part of the time part of the time part of the t	#3									Relationship to Unita:				
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Image:       Phone Type       Phone Number       Relationship to Child:         Address:       Phone Type       Phone Number       Relationship to Child:         City:       It       H       W       M       P       []       Image part of the time time part of the time part of the time part of the t	ont	-								)				
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IN COMP COLOR OF COMPT         EMERGENCY MEDICAL CARE INFORMATION         Doctor Name:       Address:       City:       State:       Zip:       Phone:         0       Optimis Name:       Address:       City:       State:       Zip:       Phone:       (       )         Preferred Hospital       Address:       City:       State:       Zip:       Phone:       (       )         INSURANCE INFORMATION         Medicaid Eligibility Status:       On Medicaid       Not Eligible       Potentially Eligible       Medicaid Number:         Primary Health Coverage:       Insurance Company/Number:       Insurance       Pomp/Number:         Income Status:       Eligible       Over Income       Public Assistance (TANF)       Total Family Income:       Pt.         Elig. Age:       Pt.       Elig. Disabled:       Pt.       Elig. Income:       Pt.         Elig. Age:       Pt.       Elig. Disabled:       Pt.       Elig. Income:       Pt.         Interctions to Living (Physical ) Address – For Home Visits or Other Information, as Deemed Necessary         Directions to Living (Physical ) Address – For Home Visits or Other Information, as Deemed Necessary       Interctions to Home:       Interct on tother       Interct on tother       I	#4						Phone Type	)		Phone Numbe	r	Relation	onship to Child:	
IN COMP COLOR OF COMPT         EMERGENCY MEDICAL CARE INFORMATION         Doctor Name:       Address:       City:       State:       Zip:       Phone:         0       Optimis Name:       Address:       City:       State:       Zip:       Phone:       (       )         Preferred Hospital       Address:       City:       State:       Zip:       Phone:       (       )         INSURANCE INFORMATION         Medicaid Eligibility Status:       On Medicaid       Not Eligible       Potentially Eligible       Medicaid Number:         Primary Health Coverage:       Insurance Company/Number:       Insurance       Pomp/Number:         Income Status:       Eligible       Over Income       Public Assistance (TANF)       Total Family Income:       Pt.         Elig. Age:       Pt.       Elig. Disabled:       Pt.       Elig. Income:       Pt.         Elig. Age:       Pt.       Elig. Disabled:       Pt.       Elig. Income:       Pt.         Interctions to Living (Physical ) Address – For Home Visits or Other Information, as Deemed Necessary         Directions to Living (Physical ) Address – For Home Visits or Other Information, as Deemed Necessary       Interctions to Home:       Interct on tother       Interct on tother       I	ict ;						нмсм	Ρ	(	)			mergency Contact	
IN COMP COLOR OF COMPT         EMERGENCY MEDICAL CARE INFORMATION         Doctor Name:       Address:       City:       State:       Zip:       Phone:         0       Optimis Name:       Address:       City:       State:       Zip:       Phone:       (       )         Preferred Hospital       Address:       City:       State:       Zip:       Phone:       (       )         INSURANCE INFORMATION         Medicaid Eligibility Status:       On Medicaid       Not Eligible       Potentially Eligible       Medicaid Number:         Primary Health Coverage:       Insurance Company/Number:       Insurance       Pomp/Number:         Income Status:       Eligible       Over Income       Public Assistance (TANF)       Total Family Income:       Pt.         Elig. Age:       Pt.       Elig. Disabled:       Pt.       Elig. Income:       Pt.         Elig. Age:       Pt.       Elig. Disabled:       Pt.       Elig. Income:       Pt.         Interctions to Living (Physical ) Address – For Home Visits or Other Information, as Deemed Necessary         Directions to Living (Physical ) Address – For Home Visits or Other Information, as Deemed Necessary       Interctions to Home:       Interct on tother       Interct on tother       I	onta	City:					H W C M	Ρ	(	)				
Doctor Name:       Address:       City:       State:       Zip:       Phone:       (       )         Dentist Name:       Address:       City:       State:       Zip:       Phone:       (       )         Preferred Hospital       Address:       City:       State:       Zip:       Phone:       (       )         Preferred Hospital       Address:       City:       State:       Zip:       Phone:       (       )         Medicaid Eligibility Status:       On Medicaid       Not Eligible       Potentially Eligible       Medicaid Number:       (       )         Primary Health Coverage:       Insurance Company/Number:       Insurance Company/Number:       Phone:       (       )         Income Status:       Eligible       Over Income       Public Assistance (TANF)       Total Family Income:       Pt.         Elig. Parent Status:       Pt.       Elig. Disabled:       Pt.       Elig. Income:       Pt.         Elig. Age:       Pt.       Transportation: Not provided       Pt.       0       Total Eligibility Points:         Directions to Living (Physical ) Address – For Home Visits or Other Information, as Deemed Necessary       Directions to Home:	ŭ	State:		Zip	):		нwсм	Ρ	(	)		Phone	Note:	
Dentist Name:       Address:       City:       State:       Zip:       Phone:         Preferred Hospital       Address:       City:       State:       Zip:       Phone:       ( )         Preferred Hospital       Address:       City:       State:       Zip:       Phone:       ( )         Preferred Hospital       Address:       City:       State:       Zip:       Phone:       ( )         Income Status:       On Medicaid       Not Eligible       Potentially Eligible       Medicaid Number:       Primary Health Coverage:       Insurance Company/Number:         Income Status:       Eligible       Over Income       Public Assistance (TANF)       Total Family Income:       Pt.         Elig. Parent Status:       Pt.       Elig. Disabled:       Pt.       Elig. Income:       Pt.         Elig. Age:       Pt.       Elig. Disabled:       Pt.       Elig. Income:       Pt.         Elig. Age:       Pt.       Transportation: Not provided       Pt.       0       Total Eligibility Points:         Directions to Living (Physical ) Address – For Home Visits or Other Information, as Deemed Necessary       Directions to Home:				ME	RGENCY ME	DICA		NFC	ORMA	TION				
Preferred Hospital Address: City: State: Zip: Phone:   INSURANCE INFORMATION   Medicaid Eligibility Status: On Medicaid Not Eligible Potentially Eligible Medicaid Number:   Primary Health Coverage: Insurance Company/Number:   Income Status: Eligible Over Income Public Assistance (TANF) Total Family Income:   Income Status: Pt. Elig. Disabled: Pt. Elig. Income: Pt.   Elig. Age: Pt. Elig. Disabled: Pt. Elig. Income: Pt.   Elig. Age: Pt. Transportation: Not provided Pt. 0   Total Eligibility Points: Income VISIT INFORMATION Pt. Eligibility Points:   Directions to Living (Physical ) Address – For Home Visits or Other Information, as Deemed Necessary Information, as Deemed Necessary   Directions to Home:							-						( )	
INSURANCE INFORMATION         Medicaid Eligibility Status:       On Medicaid       Not Eligible       Medicaid Number:         Primary Health Coverage:       Insurance Company/Number:         Insurance Company/Number:         Primary Health Coverage:         Insurance Company/Number:         Insurance Company/Number:         Over Income       Public Assistance (TANF)       Total Family Income:         Elig. Parent Status:       Pt.       Elig. Disabled:       Pt.       Elig. Income:       Pt.         Elig. Age:       Pt.       Elig. Disabled:       Pt.       Elig. Income:       Pt.         Directions to Living (Physical ) Address – For Home Visits or Other Information, as Deemed Necessary         Directions to Home:         MILITARY STATUS         Number of miles from Center:       MILITARY STATUS         Is at least one parent/guardian, who is a member of the United States military? Yes No         Is at least one parent/guardian a veteran of the United States military? Yes No       No						-						( )		
Medicaid Eligibility Status:       On Medicaid       Not Eligible       Potentially Eligible       Medicaid Number:         Primary Health Coverage:       Insurance Company/Number:         APPLICATION ELIGIBILITY INFORMATION – ELIGIBILITY PRIORITY SYSTEM         Income Status:       Eligible       Over Income       Public Assistance (TANF)       Total Family Income:         Elig. Parent Status:       Pt.       Elig. Disabled:       Pt.       Elig. Income:       Pt.         Elig. Age:       Pt.       Elig. Disabled:       Pt.       Elig. Income:       Pt.         HOME VISIT INFORMATION         Directions to Living (Physical ) Address – For Home Visits or Other Information, as Deemed Necessary         Directions to Home:	Prefe	rred Hospital	Address:				City: State: Zip:				Zip:		Phone:	
Primary Health Coverage:       Insurance Company/Number:         APPLICATION ELIGIBILITY INFORMATION - ELIGIBILITY PRIORITY SYSTEM         Income Status:       Eligible       Over Income       Public Assistance (TANF)       Total Family Income:         Elig. Parent Status:       Pt.       Elig. Disabled:       Pt.       Elig. Income:       Pt.         Elig. Age:       Pt.       Elig. Disabled:       Pt.       Elig. Income:       Pt.         Elig. Age:       Pt.       Transportation: Not provided       Pt.       0       Total Eligibility Points:         Directions to Living (Physical ) Address – For Home Visits or Other Information, as Deemed Necessary         Directions to Home:					INSURA	NCE	INFORMA	TIO	N	I			<u> </u>	
APPLICATION ELIGIBILITY INFORMATION - ELIGIBILITY PRIORITY SYSTEM         Income Status:       Eligible       Over Income       Public Assistance (TANF)       Total Family Income:         Elig. Parent Status:       Pt.       Elig. Disabled:       Pt.       Elig. Income:       Pt.         Elig. Age:       Pt.       Elig. Disabled:       Pt.       Elig. Income:       Pt.         Elig. Age:       Pt.       Transportation: Not provided       Pt.       0       Total Eligibility Points:         MOME VISIT INFORMATION         Directions to Living (Physical ) Address – For Home Visits or Other Information, as Deemed Necessary         Directions to Home:			On Medicaid	No	ot Eligible Poter	ntially E	ligible							
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Homeless       Foster       SSI         Elig. Parent Status:       Pt.       Elig. Disabled:       Pt.         Elig. Age:       Pt.       Transportation: Not provided       Pt.       Total Eligibility Points:         Elig. Age:       Pt.       Transportation: Not provided       Pt.       Total Eligibility Points:         Directions to Living (Physical ) Address – For Home Visits or Other Information, as Deemed Necessary       Directions to Home:			1										Λ	
Elig. Age:       Pt.       Transportation: Not provided       Pt. 0       Total Eligibility Points:         MOME VISIT INFORMATION         Directions to Living (Physical ) Address – For Home Visits or Other Information, as Deemed Necessary         Directions to Home:			ss I		oster		SI		ANF)			e:		
HOME VISIT INFORMATION         Directions to Living (Physical ) Address – For Home Visits or Other Information, as Deemed Necessary         Directions to Home:	•		Pt.		Elig. Disabled:		F	Pt.		Ū			Pt.	
Directions to Living (Physical ) Address – For Home Visits or Other Information, as Deemed Necessary   Directions to Home:     Directions to Home:     Number of miles from Center:     MILITARY STATUS   Is at least one parent/guardian, who is a member of the United States military, on active duty? Yes No   Is at least one parent/guardian a veteran of the United States military? Yes No	Elig. /	Age:	Pt.		Transportation	: Not p	rovided F	Pt. 0	)	Total Eligib	ility Poi	nts:		_
Directions to Living (Physical ) Address – For Home Visits or Other Information, as Deemed Necessary   Directions to Home:     Directions to Home:     Number of miles from Center:     MILITARY STATUS   Is at least one parent/guardian, who is a member of the United States military, on active duty? Yes No   Is at least one parent/guardian a veteran of the United States military? Yes No					HOME V	ISIT	INFORMA	TIO	<b>N</b>					
Number of miles from Center:	Direc		al) Address	5 – Fe						emed Necess	ary			
Is at least one parent/guardian, who is a member of the United States military, on active duty? Yes No If yes, please list the name(s) Is at least one parent/guardian a veteran of the United States military? Yes No		Directions to Home:												
Is at least one parent/guardian, who is a member of the United States military, on active duty? Yes No If yes, please list the name(s) Is at least one parent/guardian a veteran of the United States military? Yes No														
Is at least one parent/guardian, who is a member of the United States military, on active duty? Yes No If yes, please list the name(s) Is at least one parent/guardian a veteran of the United States military? Yes No														
Is at least one parent/guardian, who is a member of the United States military, on active duty? Yes No If yes, please list the name(s) Is at least one parent/guardian a veteran of the United States military? Yes No	Number of miles from Center:													
If yes, please list the name(s)	MILITARY STATUS													

#### ENROLLMENT APPLICATION

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#### SOUTHEASTERN COMMUNITY ACTION PARTNERSHIP, INC.. EARLY HEAD START PROGRAM

Applicant's Legal Name:				Date of Birth:							
·· ·	(Last)	(First)	(Middle)	-	(00/00/0000)						
AFFIRMATION											
Under penalty of perjury, I affirm that I am the parent or legal guardian of the child applying for Head Start, and that, to the best of my knowledge, all of the information that I have provided is complete and correct. I understand that if I deliberately misrepresent my family circumstances, my family will not be eligible for further services.											
<i>Emergency Medical Care Information</i> : Additionally, I, as the parent/guardian, authorize the center to obtain medical attention for my child in an emergency.											
Parent/Guardian Signature:	Application Date:										
Verifying Staff Member (Staf	f that completed applicat	ion):		Application Date:							
<i>Emergency Medical Care Information:</i> I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or any medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian.											
Signature of Center Manage	r (Administrator):			Date:							
Date of Enrollment (Child's First Day of Class):											

### Please attach a copy of the following:

- 1. Document(s) that verifies income.
- 2. Birth Certificate copy
- 3. Foster care documents, court orders (such as, but not limited to: custody or restraining orders), and/or other pertinent documents (if applicable).
- 4. Medical Plan (if applicable)
- 5. Current Immunization Record- copy only
- 6. Current Medical Physical- copy

#### If your child have any of these plans, please have available:

- 1. Individual Education Plan (IEP) Disabilities/Mental Health
- 2. Person Centered Plan (PCP) Mental Health
- 3. Plan of Care (POC) same as a TP Disabilities/Mental Health
- 4. Treatment Plan (TP) same as a POC Disabilities/Mental Health

# Note to staff:

All documents must be attached, enclosed, or uploaded to all copies for the following files: Office, Center, and "Ready-To-Go" File.

Applications may be completed on the Childplus Data Engine App.