ENROLLMENT APPLICATION

SOUTHEASTERN COMMUNITY ACTION PARTNERSHIP, INC.
EARLY HEAD START PROGRAM

Applicant's Legal Name: _____ **Date of Birth:** _____
(Last) (First) (Middle) (00/00/0000)

Center Name: _____ **Class Age:** 2 **For Program Year:** _____

PRIMARY ADULT – PARENT/GUARDIAN

Last:	First:	Middle Initial:	Preferred:	Suffix:

Social Security Number:	Date of Birth:	Single or Two Parent Home:	Gender: M F

Lives with Family? Yes No	Provides Financial Support? Yes No	Highest Grade Completed:	Employment Status:	In Training/School: Yes No

Race: (List all that apply)	Nationality:	Ethnicity:	Relationship to Applicant	Teen Parent: Yes No	Former HS Parent: Yes No

Primary Language Spoken In Home: ☐ English ☐ Spanish ☐ Other (List)	Primary Language:	English Proficiency: **O** = None **1** = Poor **2** = Moderate **3** = Proficient

LIVING ADDRESS

Living (Physical) Address:

City	State:	Zip:	County: Bladen, Brunswick, Columbus Hoke, Scotland, Robeson

Mailing Address: (If Different)

City	State:	Zip:

PHONE NUMBERS AND EMAIL ADDRESSES

Type	Primary	Phone Number	Email Address
H = Home W = Work C = Cell M = Message	Yes No		
H = Home W = Work C = Cell M = Message	Yes No		

GENERAL

Parental Status: One Two	Primary Language at Home:		Homeless: Yes No
Number in Family:	Number of Children:	By Age: 0-3 4-5	Number in Household:

INCOME SUPPORT

TANF Status: Yes No Former	SSI: Yes No	WIC: Yes No	SNAP: Yes No	Foster Care: Yes No

FAMILY INCOME (ATTACH INCOME DOCUMENTATION)

Family Member	Date	Employer/ Income Source	Gross Amount	x	Per	=	Annual Amount	Desc	Verification
			$	x		=	$		
			$	x		=	$		

Total Family Income $

Calculation for Annual Amount		Description Codes	Verification Codes
Twice a month x 24 =Annual Monthly x 12 = Annual	Weekly x 50 = Annual Bi-weekly x 25 = Annual	PEN – Pension SS – Social Security SSI – Supplemental Security Income	CS – Check Stub EL – Employer Letter TANF W2 1040 ESC – Unemployment SSI Foster No Income

SECONDARY ADULT – PARENT/GUARDIAN

Last:	First:	Middle Initial:	Preferred:	Suffix:

Social Security Number:	Date of Birth:	Single or Two Parent Home:	Gender: M F

Lives with Family? Yes No	Provides Financial Support? Yes No	Highest Grade Completed:	Employment Status:	In Training/School: Yes No

Race: (List all that apply)	Nationality:	Ethnicity:	Relationship to Applicant:	Teen Parent: Yes No	Former HS Parent: Yes No

Language(s) Spoken (Check all that apply): ☐ English ☐ Spanish ☐ Other (List):	Primary Language:	English Proficiency: O = None 1 = Poor 2 = Moderate 3 = Well

Applicant's Legal Name: _____ **Date of Birth:** _____
(Last) (First) (Middle) (00/00/0000)

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	Relationship to Applicant	Participation Status	Race	Primary Language	English Proficiency
			M F					
			M F					
			M F					
			M F					
			M F					

APPLICANT INFORMATION

Last	**First**	**Middle Name**	**Preferred:**	**Suffix:**
Social Security Number:	**Date of Birth:**		**Is this a foster child?:** Yes No	**Gender:** M F
Race: (List all that apply)	**Nationality:** (Country)	**Ethnicity:**		**Custody:** Yes No
Language(s) Spoken (Check all that apply): ☐ English ☐ Spanish ☐ Other		**Primary Language:**	**English Proficiency:** O = None 1 = Poor 2 = Moderate 3 = Proficient	
Primary Adult's Name:		**How Is Applicant Related To Primary Adult:**		

Birth Verified: Yes No By: Certified Birth Cert. Hospital Birth Cert. Health Dept. Cert. Other:

HEALTH CARE NEEDS: DISABILITIES, HEALTH, MENTAL HEALTH, NUTRITION, FAMILY CRISIS, AND REFERRAL INFORMATION

For any child with health care needs, such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child's parent or health care professional.

Is there a medical action plan attached? Yes___ No___

List any allergies and the symptoms and type of response required for allergic reactions._____

_____

List any health care needs or concerns, symptoms of and type of response for these health care needs or concerns._____

_____

List any particular fears or unique behavior characteristics the child has: _____

_____

List any types of medication taken for health care needs: _____

Share any other information that has a direct bearing on assuring safe medical treatment for your child: _____

_____

Is child receiving therapy? Yes___ No___ Suspected___ (If yes, give diagnosis and list the therapy service provider: Diagnosis:._____

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 referring.)*_____

Any specific family need or crisis? Yes___ No___ *(If yes, describe.)*_____

CONTACTS (PLEASE COMPLETE ALL INFORMATION)

Contact #1					
	Name:		**Phone Type**	**Phone Number**	**Relationship to Child:**
	Address:		H W C M P	( )	☐ **Emergency Contact**
	City:		H W C M P	( )	☐ **Release To**
	State:	**Zip:**	H W C M P	( )	**Phone Note:**

Applicant's Legal Name: _____ **Date of Birth:** _____
(Last) (First) (Middle) (00/00/0000)

Contact #2	**Name:**	**Phone Type**	**Phone Number**	**Relationship to Child:**
	Address:	H W C M P	( )	☐ Emergency Contact
	City:	H W C M P	( )	☐ Release To
	State: **Zip:**	H W C M P	( )	**Phone Note:**
Contact #3	**Name:**	**Phone Type**	**Phone Number**	**Relationship to Child:**
	Address:	H W C M P	( )	☐ Emergency Contact
	City:	H W C M P	( )	☐ Release To
	State: **Zip:**	H W C M P	( )	**Phone Note:**
Contact #4	**Name:**	**Phone Type**	**Phone Number**	**Relationship to Child:**
	Address:	H W C M P	( )	☐ Emergency Contact
	City:	H W C M P	( )	☐ Release To
	State: **Zip:**	H W C M P	( )	**Phone Note:**

EMERGENCY MEDICAL CARE INFORMATION

Doctor Name:	**Address:**	**City:**	**State:**	**Zip:**	**Phone:** ( )
Dentist 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:**

APPLICATION ELIGIBILITY INFORMATION – ELIGIBILITY PRIORITY SYSTEM

Income Status: ☐ Eligible ☐ Homeless	☐ Over Income ☐ Foster	☐ Public Assistance (TANF) ☐ SSI	**Total Family Income:**
Elig. Parent Status: **Pt.**	**Elig. Disabled:** **Pt.**	**Elig. Income:** **Pt.**	
Elig. Age: **Pt.**	**Transportation: Not provided** **Pt. 0**	**Total Eligibility Points:**	

HOME VISIT INFORMATION

Directions to Living (Physical) Address – For Home Visits or Other Information, as Deemed Necessary

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___
If yes, please list the name(s) _____

Is at least one parent/guardian a veteran of the United States military? Yes___ No___
If yes, please list the name(s) _____

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.

Emergency Medical Care Information:
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 (Staff that completed application):	**Application Date**:

Emergency Medical Care Information:
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 Manager (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.