ENROLLMENT APPLICATION

SOUTHEASTERN COMMUNITY ACTION PARTNERSHIP, INC.
HEAD START PROGRAM

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

Center Name: ______ **Class Age:** ______ **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: ______________________ (Last) (First) (Middle) **Date of Birth:** __________ (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: 0 = 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			Phone Type	Phone Number	Relationship to Child:
	Name:				
	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: ______________________________ (Last) (First) (Middle) **Date of Birth:** __________ (00/00/0000)

			Phone Type	Phone Number	Relationship to Child:
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:

OFFICE USE ONLY: 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.	Elig. Distance Pt.		Total Eligibility Points:

TRANSPORTATION INFORMATION

Applicant Transportation: Bus Walking Parent Other

Pick-Up Location:

Drop-Off Location:

Directions to Home:

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: ______ (Last) (First) (Middle)	**Date of Birth:** ______ (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.