



# Head Start - Early Head Start - LACOE State Preschool APPLICATION FOR SERVICES (PART 1 OF 2)



CHILD PLUS ID (APPLICANT):

## A. GENERAL INFORMATION

Agency Name	Site Name	Application Date	Referred By

## B. FAMILY MEMBERS

Number of People in Family	Date of Birth	Applicant's Relationship
B1. PARENT/GUARDIAN A		

EMPLOYMENT STATUS     Student     Homemaker     Unemployed     Employed     Self-Employed

CHECK ALL THAT APPLY     Has Custody of Applicant     Lives with Family     Teen Parent

EDUCATION     Less than High School Grad. (Highest Grade \_\_\_\_\_)     High School Graduate  
 Some College, Vocational or Associate Degree     Bachelor's or Advanced Degree

B2. PARENT/GUARDIAN B		
-----------------------	--	--

EMPLOYMENT STATUS     Student     Homemaker     Unemployed     Employed     Self-Employed

CHECK ALL THAT APPLY     Has Custody of Applicant     Lives with Family     Teen Parent

EDUCATION     Less than High School Grad. (Highest Grade \_\_\_\_\_)     High School Graduate  
 Some College, Vocational or Associate Degree     Bachelor's or Advanced Degree

B3. Additional Family Members (Attach Additional Sheet if Necessary)	Date of Birth	Applicant's Relationship
--	---------------	--------------------------


## C. APPLICANT (CHILD OR PREGNANT MOTHER APPLYING FOR SERVICES)

First Name	Middle Name	Last Name	Date of Birth	Gender
				<input type="checkbox"/> Male <input type="checkbox"/> Female

Race	Ethnicity	Primary Health Coverage
<input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Bi-Racial/Multi-Racial <input type="checkbox"/> Other: _____	<input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic or Non-Latino Origin	<input type="checkbox"/> Medicaid (Medical) <input type="checkbox"/> SCHIP <input type="checkbox"/> Private <input type="checkbox"/> None <input type="checkbox"/> Other: _____

Living Address	Address Line 2	Zip Code	City	State

Mailing Address (If Different)	Address Line 2	Zip Code	City	State

Contact Number	Type (Check One)	Alternative Number	Type (Check One)
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other

E-Mail Address	Parental Status
	<input type="checkbox"/> One Parent <input type="checkbox"/> Two Parents

Primary Language of Family at Home (Select One)	
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Native Central or South American and Mexican Languages <input type="checkbox"/> Caribbean Languages <input type="checkbox"/> Middle Eastern & South Asian Languages <input type="checkbox"/> East Asian Languages	<input type="checkbox"/> Native North American/Alaskan Native Languages <input type="checkbox"/> Pacific Island Languages (e.g. Palauan, Fijian) <input type="checkbox"/> European/Slavic Languages <input type="checkbox"/> African Languages <input type="checkbox"/> Other (e.g. American Sign Language): _____

Applicant's Primary Language     English     Spanish     Asian Language     Other: \_\_\_\_\_

Language(s) spoken to child by the parent(s)/primary caregiver(s)?     English     Spanish     Asian Language     Other: \_\_\_\_\_



# Head Start - Early Head Start - LACOE State Preschool APPLICATION FOR SERVICES (PART 2 OF 2)



## D. ELIGIBILITY

### D1. Family Residency Questionnaire

CHILD LIVES WITH  1 Parent or Guardian  2 Parents or Guardians  1 Parent & Another Adult  A Relative  
 An Adult (Not Parent or Guardian)  Other: \_\_\_\_\_

#### FAMILY LIVING SITUATION: (CHECK ALL THAT APPLY)

None of the Options Apply  Transitional Housing Program Name: \_\_\_\_\_  
 Shelter Name: \_\_\_\_\_  Other places not designed for or ordinarily used as a regular sleeping  
 Motel/Hotel Name: \_\_\_\_\_ accommodation for human beings (explain)  
 Single Room Occupancy (SRO)

#### Temporarily in one of the following **due to inadequate housing, financial hardship, or loss of housing:**

Car, Trailer, or Campsite  Rented Trailer, Motor Home on Private Property  Rented Garage  
 Another Family's House or Apartment  With Another Adult (Not the Parent or Legal Guardian)

### D2. Age Eligibility

#### BIRTH DATE VERIFICATION

Birth Certificate  
 Passport  
 Baptismal Certificate  
 Other: \_\_\_\_\_

### D3. Categorical Eligibility (If *not* Categorically Eligible, must Complete Section D4)

If the family is categorically eligible, select one of the boxes below and attach appropriate documentation.  
*The documentation must be current (within six months from the date of application for services) to show family is receiving services.*

TANF/CalWorks  Supplemental Security Income  Homeless  Foster Care  
*Note: If family is categorically eligible do not complete the D4 Income Eligibility section of this form.*

### D4. Income Eligibility

#### Parent/Guardian A:

Occupation: \_\_\_\_\_ Years at Present Employer: \_\_\_\_\_

Column A Current YTD	Column B Time Period Covered / Type of Income Documentation	Column C Prior YTD	Column D Time Period Covered / Type of Income Documentation

Total Income Parent/Guardian A: \$

#### Parent/Guardian B:

Occupation: \_\_\_\_\_ Years at Present Employer: \_\_\_\_\_

Column A Current YTD	Column B Time Period Covered / Type of Income Documentation	Column C Prior YTD	Column D Time Period Covered / Type of Income Documentation

Total Income Parent/Guardian B: \$

Total Family Income (Parent/Guardian A + Parent/Guardian B): \$

## E. SELECTION CRITERIA

Disability Status	Applicant Status (Check all that apply)	Crisis (Check all that apply)	Parent/Guardian (Check all that apply)
<input type="checkbox"/> None <input type="checkbox"/> IEP <input type="checkbox"/> RTI <input type="checkbox"/> IFSP <input type="checkbox"/> Suspected	<input type="checkbox"/> Transitioning EHS Student <input type="checkbox"/> Returning Student <input type="checkbox"/> 5 Year Old - Kindergarten Unavailable <input type="checkbox"/> Agency Referral	<input type="checkbox"/> Child Protective Services <input type="checkbox"/> Incarcerated Parent <input type="checkbox"/> Domestic Abuse <input type="checkbox"/> DCFS Case	<input type="checkbox"/> In Military <input type="checkbox"/> Pregnant Mother <input type="checkbox"/> Disabled <input type="checkbox"/> Grandparent

Additional Criteria  
(Capture from Page 1)

**Parental Status** (One Parent, Teen Parent)

**Parent Education** (Education Level & Student Status)

**Health Coverage** (No Insurance)

**Dual Language Learner**

Application Notes / Clarifications / Special Circumstances:

*I certify that the information about the family, income and number of persons in this family given above is true and correct.*

*I have reviewed the above documentation and verify that the information is true and correct to the best of my knowledge.*

Signature of Parent/Guardian or Client	Date Signed	Signature of Head Start Staff	Date Signed
--	-------------	-------------------------------	-------------