

Child's Name _____

St. John the Baptist Parish School Board
118 West 10th Street * P. O. Drawer AL * Reserve, Louisiana 70084

HEAD START PROGRAM 2019-2020

HEAD START is a federal program for low-income families who are eligible within the income guidelines. It provides services for all children; a sound educational program, nutritional program, social services, parental involvement, and medical/dental health services.

Your child must be three (3) years old by September 30, 2019 to be eligible for this program (offered only at West. St. John Elementary).

Applications should be submitted in person at one of the following addresses:

Garyville/Mt. Airy Math & Science Magnet School	West St. John Elementary
240 Hwy 54	2555 Hwy 18
Garyville, LA 70051	Edgard, LA 70049

ADDITIONAL INFORMATION NEEDED WITH APPLICATION:

1. **Income Verification-Your family income must be verified before your child's eligibility for Head Start can be determined. ATTACH ONE PROOF OF INCOME LISTED BELOW IN A-K:**
 - a. **Income Tax Form 1040 for the previous calendar year (2018)**
 - b. **W-2 Statements for all working family members for the previous calendar year**
 - c. **Pay Stubs *******(last 2 current) for all working family members**
 - d. **Documentation showing current status/amount received from FITAP**
 - e. **Letter showing current status/amount received from SSI/Social Security**
 - f. **Foster Care documentation letter for Foster Child**
 - g. **Documentation of Child Support/Alimony**
 - h. **Documentation of Unemployment Compensation**
 - i. **Written statement from current employer(s)**
 - j. **Written statement of Family Support from person supporting the child**
 - k. **Income Declaration Form**
2. **Child's Birth Certificate-to verify age of child**
3. **Child's Social Security Card**
4. **Child's Medical Insurance or Medicaid Card**
5. **Documentation of Child's Disability-IEP or IFSP (if applicable)**
6. **Child's Immunization Record-to show that child is up-to-date on all shots**
7. **Proof of residency-any 2 of the following: Utility bills (light, water, gas, phone or cable), Voter registration card, License/ID, Lease/Mortgage**
8. **Identification**
9. **Budget sheet if receiving SNAP benefits**

If you need assistance in obtaining any of the above information, the St. John Parish Head Start staff can assist you with contact phone numbers, applications (for birth certificate or social security card), physical exam form, or other assistance you might need in obtaining the above needed information. For more information, call St. John Head Start/PreK Program at (985) 535-3917.

FOR OFFICE USE ONLY

- | | |
|-------|--------------------------------------|
| _____ | 1. <u>Head Start</u> |
| _____ | 2. <u>Child Care Provider</u> |

St. John Parish School Board Preschool ENROLLMENT APPLICATION

Date of Application _____

Child's name: _____
First Name
Middle Initial
Last Name

Date of birth: ____/____/____ SSN: ____-____-____ Gender: ___M ___F

Head of Household Name: _____ Birth date: _____

Home Address: _____ City _____ Zip _____

Mailing Address: _____ City _____ Zip _____

Telephone: _____ Cell Number: _____

Subdivision/Area: _____

Child's Race: _____ If bi-racial, specify races: _____

Is child Latino/Hispanic: ___Yes ___No If yes, ___Black Hispanic ___White Hispanic

Language(s) spoken: Primary: _____ Other: specify: _____
 English fluency: ___Not At All ___Not Well ___Well ___Very Well

Child previously enrolled in Early Head Start, Head Start, or other Childhood Development program: ___Yes ___No

Are there Concerns about this child's overall health and development: ___Yes ___No
 If YES, WHAT concerns: _____

Child Health Insurance: ___LACHIP ___Medicaid ___Private Insurance ___No Insurance
 ___Other-Specify: _____

Child's Medical Providers-Doctor/Clinic: _____
 Dentist: _____

Child's General Health: ___Glasses ___Braces ___Wheel Chair ___Crutches ___Hearing Aid
 ___Other-Specify: _____

Child's Allergies: _____ Child's Medication(s): _____

Do you suspect a disability: ___Yes ___No

Does Child have an IEP or IFSP: ___Yes ___NO
 If yes, what is your child's DIAGNOSED disability: _____

Established Risks (check all that apply):

<input type="checkbox"/> None	<input type="checkbox"/> Sensory Impairment (i.e. hearing or vision impairment)
<input type="checkbox"/> Chromosomal abnormality (i.e. down syndrome)	<input type="checkbox"/> Congenital birth defect (i.e. myelomeningocele)
<input type="checkbox"/> Congenital syndrome (i.e. fetal alcohol syndrome)	<input type="checkbox"/> HIV positive/AIDS
<input type="checkbox"/> Medically fragile	

Environmental Risks (check all that apply):

<input type="checkbox"/> None	<input type="checkbox"/> Documented child abuse or neglect
<input type="checkbox"/> Biological mother younger than 17 years old	<input type="checkbox"/> Maternal education less than 8 th grade level
<input type="checkbox"/> Family social disorganization	<input type="checkbox"/> Parental substance abuse
<input type="checkbox"/> Parental developmental disability	<input type="checkbox"/> Family member smokes in household
<input type="checkbox"/> Suspected child abuse or neglect	<input type="checkbox"/> Poverty

Mother's Name _____
 Date of Birth ____/____/____ Living with child: _____

____ Employed If Employed, work phone number ____-____ Ext. ____
 Name of Employer: _____
 Full Time: _____ Part Time: _____ Hours: _____

____ In School Last grade completed: _____
 ____ Neither Employed or In School Are you interested in Adult Education classes? _____

Father's Name _____
 Date of Birth ____/____/____ Living with child: _____

____ Employed If Employed, work phone number ____-____ Ext. ____
 Name of Employer: _____
 Full Time: _____ Part Time: _____ Hours: _____

____ In School Last grade completed: _____
 ____ Neither Employed or In School Are you interested in Adult Education classes _____

OTHER Household/Family Members (DO NOT LIST HEAD OF HOUSEHOLD OR CHILD LISTED ABOVE): (add sheet if necessary)

Name	Gender	Race	Date of Birth	Relation to Child	Occupation-Adults	Education Level-Adults	Income-Adults
1.							
2.							
3.							
4.							

Family Data:

Family in Military: Yes No Substance Abuse: Yes No
 Family Member with Disability: Yes No Teen Mother: Yes No
 Family Member Currently in Early Head Start, Head Start or other Child Development Program: Yes No

Family Type:

Biological Family Single Parent (father figure only) Single parent, Not working or Student
 Foster Family Single Parent (father figure only) living w/ partner Single Working Parent or Student
 Other family type Single Parent (mother figure only) Two Parents, Both Working or Students
 Other relative(s) Single Parent (mother figure only) living w/partner Two Parents, Neither Working or Students
 Two Parent Family Two Parents, One Working or Student

Income verified by: ____W-2 ____Check Stub ____Tax Return ____Letter ____Other _____

Receive pay from job: ____Weekly ____Every 2 weeks ____ Monthly

Yearly gross income: \$ _____ Number of adults contributing to income: _____

Number of children in family: ____ Number of adults in family: _____

Types of services or financial assistance received (Mark all that apply):

____ Medical assistance (i.e. Medicaid) ____ Food Stamps (SNAP)
 ____ Public assistance/Welfare (i.e. FITAP/TANF) ____ WIC
 ____ Social Security ____ Foster Care Subsidy
 ____ Supplemental Security Income (SSI) ____ Housing
 ____ Child Support/Alimony ____ Child Care Assistance Program
 ____ Other: Specify _____

Has your family been Homeless during the last year? __YES __NO If yes, for how long? ____months

Emergency Information

In Case of an Emergency Notify:

Name	Relationship	Address	Phone Number

ONLY the above persons have my permission to receive my child off the bus or pick my child up at the Head Start center.

Transportation Information: Parent will bring Ride Bus

Pick-up location: _____

Drop-off location: _____

Publicity Release

I give my permission for _____ to be identified with St. John Parish School Board in print (newspaper), photographs, videos, and social media.

Parent's/Guardian's Signature: _____ Date: _____

Certification: I certify that this information is true. If any part is false, my participation in this program may be terminated. I also understand that the information in this application will be held in strict confidence with the agency and is accessible to me during business hours. I have been afforded an interview giving assistance in filling out this application and obtaining information about the Head Start program.

Parent's/Guardian's Signature: _____ Date: _____

Email address: _____

Staff Member: _____ Date: _____

Position _____