Williston/Trenton Head Start 2011/2012 Child Application P.O. Box 1407, Williston, ND 58802-1407
Phone: (701)572-2346 Fax: (701) 572-0494

Child Information

Legal Name: Last _____ First _____ Middle _____

Birthday: _____/_____/20_____ Age: _____ (by July 31st) Sex: Male Female

General Information

Living Address:_____ City _____
Mailing Address: _____ City _____

Phone Number	Home, Work, Cell or Message #	Primary Phone ?	Notes

Number in Household: ___ Number in Family ___ Total Number of Children: ___ 0-3 Years ___ 4-5 Years

Parental Status: Married Separated/Divorced Single Single/Living w/ Partner

Primary Language at Home: _____

Mother's Name_____

Address (if different than family) _____
_____

Email: _____

Birthday: _____/_____/_____

Education Level Completed (Check highest achieved):
___Grade 9 or less ___GED
___Grade 10 ___College/Advance Training
___Grade 11 ___Training Certificate
___Grade 12 ___Associate Degree
___High School Grad ___Post Graduate Degree

Employment Status (Check one):
___Full time (35 hrs/week or more) ___Disabled/Retired
___Full time & training/school ___Seasonal
___Part time (under 35 hours) ___Training/school
___Part time & training/school ___Unemployed

Nationality:

Lives with family? Yes No Teen Parent? Yes

Provides financial support? Yes No

Father's Name_____

Address (if different than family) _____
_____

Email: _____

Birthday: _____/_____/_____

Education Level Completed (Check highest achieved):
___Grade 9 or less ___GED
___Grade 10 ___College/Advance Training
___Grade 11 ___Training Certificate
___Grade 12 ___Associate Degree
___High School Grad ___Post Graduate Degree

Employment Status (Check one):
___Full time (35 hrs/week or more) ___Disabled/Retired
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___Part time & training/school ___Unemployed

Nationality:

Lives with family? Yes No Teen Parent? Yes

Provides financial support? Yes No

Household: List below anyone living in the household that is related to the applicant by blood, marriage, or adoption.

Name	Date of Birth	Gender

Emergency Contacts			
Contact 1	Name	Relationship to Child	☐ Emergency Contact ☐ Release Child To
	Phone 1 Home Work Cell	Phone 2 Home Work Cell	Phone 3 Home Work Cell
Contact 2	Name	Relationship to Child	☐ Emergency Contact ☐ Release Child To
	Phone 1 Home Work Cell	Phone 2 Home Work Cell	Phone 3 Home Work Cell
Contact 3	Name	Relationship to Child	☐ Emergency Contact ☐ Release Child To
	Phone 1 Home Work Cell	Phone 2 Home Work Cell	Phone 3 Home Work Cell

Medical/Dental Home:		
Doctor's Name	Address	Phone Number
Optometrist's Name	Address	Phone Number
Dentist's Name	Address	Phone Number

Does this child have current health coverage? No Yes If yes, the child is covered under:
Medical Assistance TISA Private Insurance Other: _____

Would you like a referral for medical coverage? Yes No

Eligibility Information:

Check any assistance received within the past 12 months:
_____Fuel Assistance _____SSI/Disability _____McKinney-Vento/Homeless Services
_____WIC _____Housing Assistance _____Child Care Assistance _____Food Stamps

Family Income (To be completed by Head Start staff)

Family Member	Amount Per:	Annual Amount	Type	Description	Verification

Certification: I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent's Signature _____ Date _____

For Office Use Only

Total Yearly Income of Family $ _____ Total Number of Family Members _____

Allowed ACYF Guideline $ _____

This child is eligible to participate in the program _____Yes _____ No

Applicable category for this child:

_____ SSI _____ Homeless _____ Foster Care _____ Public Assistance

_____ Income Eligible: _____Below federal guidelines _____Between 100-130% of federal guidelines

_____ Over-income: ___Counted as part of 10% maximum ___Counted as part of the 49% AI/AN programs

Documentation used to determine eligibility:

_____ Income Tax Form 1040 _____ W-2 _____ TANF documentation _____Unemployment

_____ Foster Care reimbursement _____ SSI documentation _____ Pay stubs

_____ Written statement from employers _____ Other (please explain) _____

Documentation of no income: _____

Staff Signature_____ Date: _____

Eligibility for Head Start is based on income and age of child, and then consideration of the following questions. All information will be kept confidential.

Child Health and Development

Does your child have severe or recurring health problems or allergies? If yes, describe: Diagnosed by: Date:	Yes	No	Pts. _____
Has your child had many ear infections or had tubes put in his/her ears? If yes, describe: PE Tubes inserted by: Date:	Yes	No	Pts. _____

Are you concerned about your child's speech development? For example, do most people have trouble understanding what your child says?	Yes	No	Pts. _____
Are you concerned about your child's language development? For example, does your child have trouble understanding what is said to him, or difficulty explaining her needs?	Yes	No	Pts. _____
Does your child receive services for special needs? Describe the nature of these services: Diagnosed by: Date:	Yes	No	Pts. _____
Is your child currently on an IFSP or received Infant Development services in the past? Describe the nature of these services:	Yes	No	Pts. _____
Do you have concerns about your child's behavior? For example, is he shy, quiet, has temper tantrums, or is overly active? If yes, please describe:	Yes	No	Pts. _____
Is your child being referred to Head Start by another agency or professional? Referred by:	Yes	No	Pts. _____

Family Information

Has any member of the child's immediate family experienced any of the following in the past 12 months? a) Separation or divorce b) Mental Health concerns c) Significant health problems d) Death of a family member e) Change in number of children in the home f) Job loss or change g) Literacy concerns h) Incarceration i) Legal problems j) Court mandated services k) Marriage l) Eviction m) Do you rent or own where you are living? (If no, who are you residing with?) _____ n) Other (please explain)	Yes a) b) c) d) e) f) g) h) i) j) k) l) m) n)	No a) b) c) d) e) f) g) h) i) j) k) l) m) n)	Pts. _____
Are you a current or past Head Start family?	Yes	No	Pts. _____
Do you have any family nearby to offer support to your family?	Yes	No	Pts. _____
Does anyone in your family speak a primary language other than English?	Yes	No	Pts. _____
Does either parent work night shift or swing shift?	Yes	No	Pts. _____
Are you a single parent?	Yes	No	Pts. _____
Do you feel you have adequate housing for the size of your family?	Yes	No	Pts. _____

Please share any concerns you might have about your child or family: