



EARLY HEAD START-CHILD CARE PARTNERSHIP (EHS-CCP) APPLICATION

Please attach the following:

- Income -12 months (1040, W-2s, TANF voucher, etc)
- Proof of Birth
- Immunizations
- TB

CHILD APPLICANT INFORMATION						
Child First Name:		Child Last Name:		Family Member of Head Start Staff? <input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____		
DOB:		Gender: Male Female		Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Child Language: <input type="checkbox"/> Bilingual		Primary Language At Home:				
Child Race (check all that apply): <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Multi-racial/Bi-racial <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unspecified <input type="checkbox"/> Other: _____						
Primary Health Coverage: <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Healthy Families <input type="checkbox"/> None <input type="checkbox"/> Other or <input type="checkbox"/> Private (Name):						
Does your child have a disability or special need? <input type="checkbox"/> Yes <input type="checkbox"/> No (Circle One): Suspected Diagnosed						
Does your child have any medical concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No List:		Doctor Name/Address/Phone Number:		Dentist Name/Address/Phone Number:		
Homeless: <input type="checkbox"/> Yes <input type="checkbox"/> No		Parental Status (circle one): Single Parent Two Parents				
Living Address:		City:		State:	Zip Code:	
Phone Numbers: Home ()		Work ()		Cell ()		
Referred by Child Welfare Agency: <input type="checkbox"/> Yes <input type="checkbox"/> No			Active Duty Military? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you receive WIC? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Do you receive TANF or SSI? <input type="checkbox"/> Yes <input type="checkbox"/> No			Parent/Guardian is a U.S Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No			
SNAP (CalFresh)? <input type="checkbox"/> Yes <input type="checkbox"/> No						
PARENT/GAURDIAN INFORMATION						
<i>LIVING IN HOUSEHOLD SUPPORTED BY THE INCOME OF THE PARENTS/GUARDIANS OF THE CHILD ENROLLED AND RELATED TO THE PARENTS BY BLOOD, MARRIAGE OR ADOPTION:</i>						
Parent/Guardian First and LastName List Primary AdultFirst	Date of Birth	Ethnicity (Hispanic/ Latino or non Hispanic/Latino)	Gender M or F	Education Status: Less than High School; High School Diploma; GED; Some college or AA; BA or advanced	Employment Status: Full-time; Part-time; Seasonal; Unemployed; Training/School;	Relationship To Child (i.e. mother, grandmother, foster, etc.)
OTHER CHILDREN IN HOME						
First and Last Name	Date of Birth	Ethnicity	Gender	Relationship to Primary Adult		
			M F			
			M F			
			M F			
			M F			

I certify under penalty of perjury that the information in this enrollment packet is true and complete to the best of my knowledge. If any part is false or omitted, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency.

PARENT/GUARDIAN SIGNATURE

DATE