LITTLE DIXIE HEAD START

Thank you for applying for ***Little Dixie Head Start*** . In order to process your child's application, copies of:

proof of income of all household members,
child's certified birth certificate or hospital birth record, and
a copy of a current immunization record

must be attached. If your child has been diagnosed with a disability, we must have a copy of any record, evaluations or IEP to consider your child for a priority based on a diagnosed disability.

You must provide proof of income for all household members. This may include work paycheck stubs, income tax forms, TANF, SSI, scholarship letter, sponsor letter, child support letter, financial aid letter, social security letter, unemployment compensation, veterans benefits, workers compensation, alimony, etc… If the child for whom you're applying is in foster care through DHS, proof of income is required for that child only.

You can mail or fax your application and appropriate paperwork to:

Little Dixie Head Start
209 North 4th
Hugo, OK. 74743

Phone: 1-866-326-7581
Fax: 1-580-326-7584

Please make sure you include proper postage on the envelope.

Acceptance into Head Start is determined by priority based on a point system. You will be notified if your child is accepted or placed on a waiting list as soon as possible.

Thank you for applying for Head Start!

LITTLE DIXIE C.A.A. Head Start
209 NORTH 4TH STREET
HUGO, OK. 74743
(580) 326-7581
1-866-326-7581

Agency Use Only

Center: _____ Age: _____
Type: _____ Language: _____
Sus. Dis: _____ Ident. Dis: _____
Prev. Child Dev. Program _____
Family: _____ Children: _____
Income: _____
Referrals: _____ **Total:** _____

Center Accepted: _____
Date Accepted: _____

HEAD START APPLICATION

Assurance of Confidentiality: The information on this form is being requested on a voluntary basis. The information you provide will help us deliver or direct services most appropriate for your family's needs. If you prefer not to provide some of the information, it will not affect the services we try to deliver. However, some information is required for eligibility determination. All information provided will be held in strict confidence.

Child's Name: _____
First Name MI Last Name

Nickname: _____ Date of Birth: _____/_____/_____

Social Security # of Applying Child: ___-___-___ Gender: ___Male ____Female

Living Address:_____ _____
Street Town/City/Zip Code

_____ _____
Home Telephone Number Work Telephone Number

_____
Message Number If Available

Mailing Address: _____ _____
Street Town/City/Zip Code

What race/ethnicity do you consider this child to be?

_____ White _____ Black _____ American Indian
_____ Asian - Please Specify: _____ _____ Other - Please Specify _____

What language does this child speak at home? Primary Language:_____

If English is the second language, how well does this child speak English?
_____ Very Well _____ Well _____ Not Well _____ Not At All

What Little Dixie Head Start center are you applying for? _____

How did you hear about Head Start? _____

Has this child been identified as having, or is suspected to have, any of the following:

	Suspected:	Identified:	Date:	Evaluated By:
Asthma	_____	_____	_____	_____
Autism	_____	_____	_____	_____
Severity: _____				
Emotional/Behavior Disorder	_____	_____	_____	_____
Severity: _____				
Aggressive Behavior	_____	_____	_____	_____
Health Impairment	_____	_____	_____	_____
Type: _____				
Hearing Impairment	_____	_____	_____	_____
Percent of Hearing loss: _____				
Mental Retardation	_____	_____	_____	_____
Down Syndrome	_____	_____	_____	_____
Severity: _____				
Orthopedic Impairment	_____	_____	_____	_____
Speech/Language Impairment	_____	_____	_____	_____
Traumatic Brain Injury	_____	_____	_____	_____
Visual Impairment	_____	_____	_____	_____
Severity:_____				
Cerebral Palsy	_____	_____	_____	_____
Severity: _____				

Has this child previously been enrolled in Head Start or other child development program?

_____ Yes _____ No

If yes, specify which progam(s) this child has attended and date(s) of attendance.

_____ Early Head Start From ____/____/____To ____/____/____
_____ Head Start Home Based From ____/____/____To ____/____/____
_____ Head Start Center Based From ____/____/____To ____/____/____
_____ Other: Specify _____ From ____/____/____To ____/____/____

Name of Primary Supporting Adult: _____

First Name MI Last Name

Relationship to Child: _____

Date of Birth: _____/_____/_____

Social Security Number of Primary Supporting Adult: _____- _____- _____

List **all household members** and their relationship to the applying child. You may attach an additional sheet of paper if necessary. ***Please only list the people living in the home.***

Father	Date of Birth	Social Security #
Mother	Date of Birth	Social Security #

Family Member	Relationship to Applying Child	Date of Birth
Family Member	Relationship to Applying Child	Date of Birth
Family Member	Relationship to Applying Child	Date of Birth

Which of the following descriptions best fits the child's family: (check only one)

_____ Foster Family
_____ Other Relatives
_____ Single Parent Family (Father Figure Only)
_____ Single Parent Family (Father Figure Only) Living With Partner
_____ Single Parent Family (Mother Figure Only)
_____ Single Parent Family (Mother Figure Only) Living With Partner
_____ Two Parent Family

How many adults are there in your family? _____ Adults
How many children are there in your family? _____ Children

What is your family's yearly gross income? $ _____

Based on the income verification you attached, how often do you get paid?
_____*(Example: Weekly, Monthly, etc.)*

Do you currently live with family or friends? _____ Yes _____ No

Does your family receive any of the following types of services or financial assistance?

_____ Medical Financial Assistance (Ex.: SoonerCare/Medicaid/Medicare)
If yes, SoonerStart/Medicaid number including person code: _____

_____ Food Stamps
_____ Public Assistance/Welfare (Ex.: TANF)
_____ WIC
_____ Supplemental Security Income (SSI)
_____ Foster Care/Adoption Subsidy
_____ Living Assistance Provided By Family or Friends
_____ Other: Specify _____

_____ Public Housing Assistance
_____ Energy Program Assistance
_____ EPSDT
_____ Child Support/Alimony
_____ Title XX Day Care Assistance

I certify the information provided in support of this application is accurate and truthful to the best of my knowledge.

Signature: _____ Date: _____/_____/_____
Parent/Guardian

AGENCY USE ONLY:

Center Applied For: _____ Referral Source: _____

Verifications:

_____ 1040 Tax Statement
_____ 1040A Tax Statement
_____ _____ Tax Statement
_____ W2 Statement
_____ Pay Stub
_____ Income Declaration
_____ Public Assistance Form
_____ Unemployment
_____ Child Support
_____ Foster Care
_____ SSI
_____ Homeless

_____ DOB
Age as of Sept.1st _____
_____ Special Needs:
_____ Applicable
_____ Not Applicable
_____ Immunization Record

_____ Is Child Head Start Eligible

Staff Signature: _____ Date: _____/_____/_____
ERSEA Specialist

Application Contact Log:

Date:	**Contact:**