

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

HEAD START APPLICATION

Agency Use Only	
Center: _____	Age: _____
Type: _____	Language: _____
Sus. Dis: _____	Ident. Dis: _____
Prev. Child Dev. Program _____	
Family: _____	Children: _____
Income: _____	
Referrals: _____	Total: _____
Center Accepted: _____	
Date Accepted: _____	

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 program(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

