NORTHERN KENTUCKY COMMUNITY ACTION COMMISSION
HEAD START ENROLLMENT APPLICATION

Parent Information

Parent\Guardian Name _____ Date of Birth _____ S.S.N _____ - _____ - _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone (_____) _____ - _____ **Cell Phone** (_____) _____ - _____ **Message Phone** (_____) _____ -- _____ **E-Mail** _____

Highest Level of Education COMPLETED _____ **Employment/School** _____ **Employer/School Name** _____

Child's Information

Child's Last Name _____ **First** _____ **Birth Date** _____/_____/_____

Child's S.S.N _____ - _____ - _____ **SEX** _____ ***Language** _____ ***Other Language** _____ **School District** _____

Is your child transitioning from an early Head Start Program? YES [ ] NO [ ]

Ethnicity: (Circle) Asian Native American Bi-Racial/ Multi Racial Black Caucasian Latino Other _____

Will you need before/after school care? [ ] NO [ ] YES

Medical Coverage: Private Insurance # _____ **Medical Card #** _____ **No Insurance [ ]**

Do you have any other children in Head Start currently? [ ] NO [ ] YES CHILD'S NAME _____

Has your child been diagnosed with a disability? [ ] NO [ ] YES (If yes, provide IEP or doctors statement)

Do you suspect that your child may have a disability? [ ] NO [ ] YES, explain _____

Family Information

Parental Status – Check One

[ ] ONE PARENT [ ] TWO PARENTS

[ ] FOSTER PARENT(S) [ ] GUARDIAN

Number of Persons

*** IN THE FAMILY** _____

***IN THE HOME** _____

Number of Children

IN THE FAMILY _____

UNDER 6 YEARS OLD _____

Name of other adults in the household	Relationship to child	Birthdate	Name(s) of other children in the household	Relationship to child	Birthdate

Additional Information

Indicate if your family receives services from any of the following: □ First Steps □ Speech Therapy □ Physical Therapy □ Every Child Succeeds □ HIPPY □ North Key

□ Behavioral or Mental Health □ Early Childhood Intervention □ CCC □Women's Crisis Center □ In Home Services □ Other/Additional Services _____

Do you receive: WIC? Yes____ No____ Food Stamps? Yes____ No_____ Are you currently expecting? YES _____ NO_____

Are you currently receiving KTAP/TANF Benefits? [ ] NO [ ] YES Are you currently receiving Kinship or Foster care reimbursement? [ ] NO [ ] YES

***Housing: Rent [ ] Own [ ] Homeless [ ] Other [ ] please explain** _____

Does anyone in the home receive SSI Benefits? [ ] NO [ ] YES WHO? _____

List income by family member, the amount being received and the period the amount covered, (weekly, monthly, annual) and from whom :

Family Member	Amount Received	Time Period	From Whom
1.			
2.			

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

PARENT\GUARDIAN SIGNATURE _____ **DATE** _____

** For Office Use Only-Do Not Write In This Box **

TOTAL ANNUAL HOUSEHOLD INCOME VERIFIED $_____

INCOME VERIFICATION: CHECK TYPE [ ] CHECK STUB [ ] W-2 FORM [ ] LETTER FROM EMPLOYER [ ] LETTER FROM K-TAP [ ] OTHER

STAFF SIGNATURE _____ **DATE** _____