

Date Received: _____

Head Start/Ready Start 2009-2010 Application

Child Information	Child's Name (Last, First)		Date of Birth:
	Home Phone #:	Message #:	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Address:		Apt. Name/#:
			City: Zip:
	We are homeless. (This means your family is staying in a car, park, campground or hotel, emergency shelter, or transitional housing or your family is living with another family temporarily): <input type="checkbox"/> No <input type="checkbox"/> Yes		
	What language(s) does the child speak?		
	Child's Ethnicity: Check ONE Box <input type="checkbox"/> Hispanic <input type="checkbox"/> Non Hispanic		
	Child's Race(s): Check ALL That Apply: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hawaiian/Pacific Islander		
	Do you think this child has a disability? <input type="checkbox"/> No <input type="checkbox"/> Yes		
	Is this child on an IEP (Special Education)? <input type="checkbox"/> No <input type="checkbox"/> Yes, name of the school district:		
Family Information	Does this child have medical insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes Name of Health Plan: Type: <input type="checkbox"/> DSHS/Medical Coupon <input type="checkbox"/> Basic Health <input type="checkbox"/> Private <input type="checkbox"/> Other:		
	Does this child have dental insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes Name of Insurance:		
	Child lives with: <input type="checkbox"/> One Parent/Guardian <input type="checkbox"/> Two parents/Guardians Name(s):		
	Child is: <input type="checkbox"/> Your Natural (Biological) or Adopted Child <input type="checkbox"/> Foster Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other:		
	Number of people in family:		Ages of other children in the home:
	Annual income: (last 12 months or last calendar year):		<div style="border: 1px solid black; width: 150px; height: 20px;"></div>
	Please send proof of your family income for the last calendar year or the last 12 months with this application. Send copies of all that apply: pay stubs, last year's W-2 forms or final tax return, TANF benefits award letter from DSHS, unemployment summary, or record of child support payments.		
	Is anyone in your family receiving SSI? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, who receives it?		
	Are you receiving a TANF grant? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what is your DSHS case number?		
	Additional Information	How did you hear about Head Start/ECEAP?	
Do you have concerns for your child? <input type="checkbox"/> No <input type="checkbox"/> Yes, please check all that apply <input type="checkbox"/> Dental Health <input type="checkbox"/> Learning Difficulties <input type="checkbox"/> Speech or Hearing <input type="checkbox"/> Behavior <input type="checkbox"/> Physical Health <input type="checkbox"/> Nutrition/Eating <input type="checkbox"/> Abuse/Neglect <input type="checkbox"/> Vision <input type="checkbox"/> Former Foster Child			
Do you have concerns for yourself or other family members? <input type="checkbox"/> No <input type="checkbox"/> Yes, please check all that apply <input type="checkbox"/> Housing <input type="checkbox"/> Job/Employment <input type="checkbox"/> Disability/Unable to work <input type="checkbox"/> Family Violence <input type="checkbox"/> Learning Difficulties <input type="checkbox"/> Drug/Alcohol Issues <input type="checkbox"/> Immigration <input type="checkbox"/> Mental Health/Illness <input type="checkbox"/> Military Deployment <input type="checkbox"/> Legal Issues <input type="checkbox"/> Health Issues <input type="checkbox"/> Incarcerated Parent <input type="checkbox"/> Teen Parent			
Are you interested in (check all that apply): <input type="checkbox"/> Part Day preschool <input type="checkbox"/> Full Day (includes preschool/childcare) <input type="checkbox"/> Home Base			
Does your family currently receive a childcare subsidy? <input type="checkbox"/> No <input type="checkbox"/> Yes Subsidy #:			

If currently in Child Care,

Name of provider:

Phone:

Special Agency Referral from:

PARENT/GUARDIAN 1

PARENT/GUARDIAN 2

Mother/Father/Other (please circle)

Mother/Father/Other (please circle)

Name:

Name:

Address if different than child:

Address if different than child:

Cell/Home Phone:

Cell/Home Phone:

Work/Message Phone:

Work/Message Phone:

E-Mail Address:

E-Mail Address:

Your Date of Birth:

Your Date of Birth:

Language(s) you speak:

Language(s) you speak:

Do you require an interpreter to access services?

Do you require an interpreter to access services?

No Yes

No Yes

Education Level (check highest completed):

Education Level (check highest completed):

Grade 8 or less GED
 Grade 9 Some College
 Grade 10 Technical Training
 Grade 11 AA
 Grade 12/HS Grad BA or Higher

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 Grade 9 Some College
 Grade 10 Technical Training
 Grade 11 AA
 Grade 12/HS Grad BA or Higher

Are you currently working?

Are you currently working?

No Yes
 Working Full Time (35 hours or more each week)
 Working Part Time (Less than 35 hrs each week)

No Yes
 Working Full Time (35 hours or more each week)
 Working Part Time (Less than 35 hrs each week)

Name of Employer: _____

Name of Employer: _____

Seasonally employed Retired
 Unemployed Disabled

Seasonally employed Retired
 Unemployed Disabled

Are you currently in school?

Are you currently in school?

No Yes, where? _____
 Full Time Part Time

No Yes, where? _____
 Full Time Part Time

Note: Transportation is provided from most areas for PART DAY PROGRAMS only.

Please complete if you are interested in transportation services.

My child would be picked up at:

Address

Phone:

My child would be dropped off at:

Address

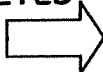
Phone:

the policy of PSESD Head Start/ECEAP not to discriminate on the basis of race, creed, religion, marital status, sexual orientation, national origin, sex, age, or mental/sensory/physical disability.

Understand that the information I have given on this application is confidential and will not be shared without permission. If applicable, I give Head Start/ECEAP staff permission to contact DSHS to verify my information.

Parent/Guardian Signature: _____

PLEASE RETURN COMPLETED APPLICATION TO



Willows Special Services/Preschool Applications
PO Box 97039
Redmond, WA 98073-9739

We will contact you soon to let you know if your child is eligible for our program.
For general information about Head Start/ECEAP, please call 1-866-KIDZ-1st