



# HEAD START/ EARLY HEAD START 2010-2011 ENGLISH

Once your application is processed, you will be notified of your child's eligibility for Orange County Head Start/Early Head Start program. All eligible children will be placed on a waiting list for an available slot in our program. **Applications are taken year round.**

## **Be sure all necessary documentation is enclosed before application is submitted**

↓ **We cannot determine your child's eligibility for our program until we receive the following:** ↓

- COMPLETE AND SIGN APPLICATION** (signature required on page 6)
- COMPLETE AND SIGN CONSENT FOR EXCHANGE OF INFORMATION** (page 5)
- PROOF OF INCOME ATTACHED** (Copy of W-2, tax statement; or at least 3 consecutive current paystubs. Also include copies of any other sources of income received ) (page 6)
- PROOF OF CHILD'S AGE ATTACHED** – (Copy of BIRTH CERTIFICATE or Passport)
- PROOF OF RESIDENCY IN ORANGE COUNTY**– (copy of any of the following documents with your name and current mailing address - electric, water, gas, phone (not cell) , cable, lease agreement, deed, tax bill)

For questions or help completing this application or with required documents please call the Orange County Head Start/Early Head Start office at 490-5577, Ext. 248 or 242

**\*Incomplete Applications will not be processed\***

***IF INTERESTED IN FULL-TIME CHILDCARE (more than 6 hours a day) in order to work or go to school you must also apply to the local subsidy agencies in Orange County:***

- **CHILD CARE SERVICES ASSOCIATION (CCSA) 967-3272**
- **ORANGE COUNTY DEPARTMENT OF SOCIAL SERVICES (DSS) 245-2800 or 968-2000**

***IF ACCEPTED INTO PROGRAM THE FOLLOWING WILL ALSO BE REQUIRED:***

- **Proof of Immunization** – copy of child's shot record
- **Proof of Physical Exam** –copy of child's most recent physical exam (within the last 12 months)

**Please mail or drop off application and all required paperwork**  
(Copies of documents can be made at either location if needed)

**Orange County Head Start/Early Head Start**  
800 Eastowne Drive, Suite 105  
Chapel Hill, NC 27514  
919-490-5577 Ext. 248 or 242

**OR**

**Fairview Child and Family Center**  
125 Lawndale Avenue  
Hillsborough, NC 27278  
919-643-4000

NAME OF CHILD APPLYING \_\_\_\_\_

AGE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**All information in this application is kept confidential**

**PARENT & FAMILY INFORMATION**

NAME OF ADULT APPLYING FOR CHILD \_\_\_\_\_

RELATIONSHIP TO CHILD \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

CITY/STATE \_\_\_\_\_

ZIP CODE \_\_\_\_\_

HOME PHONE \_\_\_\_\_

MAILING ADDRESS (If different from above) \_\_\_\_\_

CELL PHONE \_\_\_\_\_

EMAIL Address - \_\_\_\_\_

WORK PHONE \_\_\_\_\_

How long has this child lived at this address? \_\_\_\_\_

**IF YOU ARE PREGNANT:** Due Date (mm/yy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Are you receiving prenatal services?  Yes  No  
Do you have a Maternity Care Coordinator or Outreach Worker?  Yes  No Name: \_\_\_\_\_

**FAMILY'S INFORMATION:**

	Mother/Legal Guardian (If applicable)	Father/Legal Guardian (If applicable)
<b>Name:</b>		
<b>Date of Birth:</b>		
<b>What Race/Ethnicity do you consider yourself to be? (Check one)</b>	<input type="checkbox"/> White/Anglo <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Multi-racial or Other (specify): _____	<input type="checkbox"/> White/Anglo <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Multi-racial or Other (specify): _____
<b>Languages Spoken:</b>		
<b>What is the primary language spoken in your home?</b>		
<b>(If English is not your primary language)</b>	<b>How well can you speak English?</b> <input type="checkbox"/> Well <input type="checkbox"/> Some <input type="checkbox"/> Not much or none <b>How well can you read and write English?</b> <input type="checkbox"/> Well <input type="checkbox"/> Some <input type="checkbox"/> Not much or none	<b>How well can you speak English?</b> <input type="checkbox"/> Well <input type="checkbox"/> Some <input type="checkbox"/> Not much or none <b>How well can you read and write English?</b> <input type="checkbox"/> Well <input type="checkbox"/> Some <input type="checkbox"/> Not much or none
<b>What is your employment situation? (Check one)</b>	<input type="checkbox"/> Full-time (30 +hours) <input type="checkbox"/> Part-time job (29 hours or less) <input type="checkbox"/> Homemaker <input type="checkbox"/> Unemployed <input type="checkbox"/> Unable to work due to disability <input type="checkbox"/> In Job-training program: _____ <input type="checkbox"/> Self-employed (please specify): _____ <input type="checkbox"/> Actively seeking employment <input type="checkbox"/> Other: (please specify): _____	<input type="checkbox"/> Full-time (30 +hours) <input type="checkbox"/> Part-time job (29 hours or less) <input type="checkbox"/> Homemaker <input type="checkbox"/> Unemployed <input type="checkbox"/> Unable to work due to disability <input type="checkbox"/> In Job-training program: _____ <input type="checkbox"/> Self-employed (please specify): _____ <input type="checkbox"/> Actively seeking employment <input type="checkbox"/> Other: (please specify): _____
<b>Work Hours:</b>	From: _____ To: _____	From: _____ To: _____
<b>Enrolled in School?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No Where? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Where? _____
<b>Last School Grade Completed (please circle):</b>	0 1 2 3 4 5 6 7 8 9 10 11 12 <b>College?</b> 1 2 3 4 5+	0 1 2 3 4 5 6 7 8 9 10 11 12 <b>College?</b> 1 2 3 4 5+
<b>HS Diploma/GED or College Degree Received?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Degree</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Degree</b> _____

**Family Information continued:**

Name of Head of Household: \_\_\_\_\_

Does the child live with  Both Parents  Father  Mother  Foster Parent(s)  Grandparent(s)  Other \_\_\_\_\_

Who has **LEGAL** custody of the child? \_\_\_\_\_ Is this child a foster child?  Yes  No

Are both parents involved in raising this child?  Yes  No

Are there custody issues?  Yes  No If yes, please explain: \_\_\_\_\_

Are you (check one):  Single  Married  Separated  Divorced  Widowed

List below everyone who lives in the home with this child (Brothers, Sisters, Aunts, Uncles, Grandparents and Non-relatives, etc):

NAME	Sex	Age	Date of Birth	Relationship to Child

Of the total listed above, how many are supported by this child's parent(s)/legal guardian? \_\_\_\_\_

We select children based on need. Your honest answers to the following questions help us determine your family's needs.

**All information will be held in strict confidence according to program policy.**

- Yes  No Have you been granted refugee status?
- Yes  No Do you have trouble meeting your child's basic needs such as housing, healthcare, and/or food?  
If yes, please explain \_\_\_\_\_
- Yes  No Have you or your child witnessed alcohol or drug abuse in your household?  
If yes, please explain: \_\_\_\_\_
- Yes  No Has your child witnessed physical or verbal violence in your community?
- Yes  No Has your child witnessed physical or verbal violence in your home?
- Yes  No Do you feel that your house and/or neighborhood is unsafe?
- Yes  No Are you homeless or live in a shelter?
- Yes  No Have you had problems in the past with keeping a house or an apartment?
- Yes  No Does any family member living within your home, have a documented disability?  
If yes, who? \_\_\_\_\_
- Yes  No Is this family member receiving SSI (Supplemental Security Income) for disability?
- Yes  No Does either parent have a mental illness?
- Yes  No Is the parent receiving SSI for the mental illness?
- Yes  No Has your child recently lost one of his/her parents due to death or imprisonment?
- Yes  No Or due to separation, divorce or abandonment?
- Yes  No Has your family ever been involved with Child Protective Services (CPS) ?
- Yes  No Is there documented abuse or neglect?
- Yes  No Have you ever lost custody of your child?
- Yes  No Or voluntarily placed him or her in another home?
- Yes  No Do you or your child feel isolated; have little opportunity to interact with others?
- Yes  No Have there been any other serious events, which have put stress on your family recently?  
If so, please explain: \_\_\_\_\_

**CHILD'S INFORMATION**  
*(If child NOT born yet, skip this page)*

NAME OF CHILD APPLYING \_\_\_\_\_ / / \_\_\_\_\_  Male  Female  
Date of Birth

What race/ethnicity do you consider this child to be? (Check one):

- White/Anglo       Black/African-American       Native American       Asian       Pacific Islander  
 Latino/Hispanic       Multi-racial or Other (specify): \_\_\_\_\_

Has your child been in Early Head Start or other Head Start before?  Yes  No When? \_\_\_\_\_

Does your child have a sibling that is currently enrolled in Early Head Start or Head Start?  Yes  No

Does your child have a sibling that was previously enrolled in Early Head Start or Head Start?  Yes  No

Child's health insurance coverage:  Medicaid  Health Choice  None  Other \_\_\_\_\_

Was your child born at 36 weeks or less or had a birth weight of less than 3 lbs. and 4 oz.?  Yes  No

Does your child have a chronic health condition or is medically fragile? Please explain: \_\_\_\_\_

Where does the child go for check-ups, shots and other health care (please list all)? \_\_\_\_\_

**IMPORTANT: We encourage families to provide a physical exam and shot record when applying for Head Start. We require a current physical exam and shot record for all enrolled children. Please call us at 919-490-5577, ext 259 if you are having trouble getting these records.**

Has anyone expressed concerns or recommended services based on this child's health, learning, development or behavior?

- No       Yes, Family Member       Yes, Pediatrician/Health Care Professional: \_\_\_\_\_  
 Yes, Teacher       Yes, Child Service Coordinator or other caseworker: \_\_\_\_\_

If yes, please explain those concerns: \_\_\_\_\_

Has this child received any developmental screening, assessment or evaluation because of concerns about his/her behavior, health or development, or for early intervention or special education services?

- No       Yes, Preschool Exceptional Education (school system)  
 Yes, CDSA or CDL       Yes, Pediatrician       Yes, Hospital or Clinic  
 Yes, Psychologist Social Worker       Yes, CSC/Health Dept.       Yes, other: \_\_\_\_\_

If yes, did the evaluation result in eligibility for the child to receive early intervention services (such as therapy, special education, speech services)?  Yes  No  Unsure

Does your child have an current IFSP (Individualized Family Service Plan) or IEP (Individualized Education Plan)?

- Yes       No       Unsure       Not at this time but has in the past

If yes, please explain: \_\_\_\_\_

**If your child has an IFSP or IEP please provide a copy and attach to this application.**

**I am interested in...(you may select more than one)**

- Home-based services (home visits and parent-child playgroups) **FOR CHILDREN UNDER 3 YEARS and PREGNANT MOMS**
- Center-based services (in a classroom) **FOR CHILDREN 6 WEEKS TO 5 YEARS** **\*\*PLEASE SELECT ONE BELOW\*\***
- Child Care centers in Chapel Hill/Carrboro area     Fairview Child & Family Center in Hillsborough     any open slot
- Pre-K/More@4 Classroom in Orange County Elementary Schools (not Chapel Hill/Carrboro Schools)

**Do you need any of the following?**

- I need childcare to continue working and/or go to school     I need childcare to find a job.
- I need childcare to return to school/job training/other training (explain): \_\_\_\_\_

**Are you currently working and/or going to school more than 30 hours per week?**     Yes     No

**What hours do you need child care?** From: \_\_\_\_\_ To: \_\_\_\_\_

**Are you currently receiving child care subsidy?**     Yes     No    **If yes,**     This Child **and/or**     Sibling(s)

**If yes, check one:**     CCSA (Child Care Services Association)     DSS (Department of Social Services)

**If no, have you applied for child care subsidy for this child?**     Yes     No

**If yes, please check:**     CCSA **DATE APPLIED:** \_\_\_\_\_     DSS **DATE APPLIED:** \_\_\_\_\_

**Has this child ever attended a child care center or been cared for out of the home?**     Yes     No

**If yes, where?** \_\_\_\_\_    **How Long?** \_\_\_\_\_

**Is this child currently attending this child care center now?**     Yes     No

**What kind of transportation do you use?**     My car     Bus     Family/Neighbor     Other \_\_\_\_\_

**Since our Head Start Pre-K Classrooms (4 year olds) do not offer full time childcare, will you be seeking/needing additional hours of child care before 8am or after 2pm?**     Yes     No

**If yes, what is your plan for childcare?:** \_\_\_\_\_

**Please tell us how you found out about Orange County Head Start/Early Head Start. This will help us understand the best ways to reach out to families in our community (check one):**

- A posted flyer/sign I saw (where?): \_\_\_\_\_     From a friend/neighbor/family member
- From someone who works with my family (who?): \_\_\_\_\_     Newspaper
- One of the offices I go to for services (which one?) \_\_\_\_\_
- Other: \_\_\_\_\_

**Are other community agencies providing services to you or anyone else living in your house?**     Yes     No **If yes, please list below.**

AGENCY	PHONE NUMBER	PERSON'S NAME

**Agency's Comments:** \_\_\_\_\_

**Does your family receive any of the following services or assistance? (Check all that apply):**

- Foster Care     Medicaid/Medicare     Food Stamps     WIC     Housing Assistance
- SSI     SSA     TANF/Public Assistance/Work First     Unemployment     Child Support
- Dept. of Social Services – Child Care Subsidy     Child Care Services Association – Child Care Subsidy
- Child Services Coordination (Health Dept)

## Application Consent for Exchange of Information

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

The Orange County Head Start/Early Head Start program operates in partnership with community agencies serving children and families. These partnerships help us to promote access to support programs for families who are eligible to receive them. Your consent for our program staff to discuss your child's needs with other agencies will help to ensure that our services to your family are efficient and unified with other services your family may receive.

**NOTE: Eligibility for the Head Start/Early Head Start programs will not result in the loss of services you already receive.**

**We may need to exchange information contained in this application with the following:**

- Orange County Health Department (OCHD)
- Department of Social Services (DSS)– TANF/Work First, Day Care, Child Protective Services
- Durham Child Development Service Agency (CDSA)
- Child Care Services Association (CCSA)
- Orange County Partnership for Young Children/More At Four
- Chapel Hill - Carrboro City Schools
- Orange County Schools
- KidSCOpe
- OCEHS Child Care Partners - Community School for People Under Six, Frank Porter Graham Child Care Center  
Operation New Life Child Development Center, Chapel Hill Cooperative Preschool-  
Infant/Toddler Site
- Previous Early Head Start or Head Start Program or Child Care Center - **Please list name and address below** ↓

\_\_\_\_\_  
\_\_\_\_\_

**CONSENT TO EXCHANGE INFORMATION WITH CHILD'S HEALTH CARE PROVIDERS:**

**Please list your child's pediatricians and any other place your child is seen for health care or specialty care:**

- Doctor's Office/Health Care Center (please specify): \_\_\_\_\_
- Other Health Care Provider (please specify): \_\_\_\_\_

**I give my consent for the Orange County Head Start/Early Head Start program to exchange information with the agencies listed above. I understand that this consent is voluntary and is valid until my child is enrolled in a Orange County Head Start/Early Head Start program, or until I cancel this release in writing. I understand that this page of my application may be faxed to the above agencies to show my consent for this release.**

\_\_\_\_\_  
**Parent/Legal Guardian's Signature**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date**

