

# HS EHS RAB EHS-CCP (Fayette Clinton Highland) Enrollment Form

Applicant's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_ Preferred Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ City/State born \_\_\_\_\_ Gender \_\_\_\_\_ Race \_\_\_\_\_ Spoken Language \_\_\_\_\_

Participant's Home Address -Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_

Cell Phone # \_\_\_\_\_ Home Phone# \_\_\_\_\_ E-mail Address \_\_\_\_\_

Is child receiving services for: IEP/IFSP: **Y / N** Speech: **Y / N** Diagnosed disability: **Y / N**

Enrolled in Help Me Grow? **Y / N** Is parent/guardian pregnant? **Y / N** Due Date: \_\_\_\_\_

Applicant's doctor: \_\_\_\_\_ Applicant's dentist: \_\_\_\_\_

Current living arrangement: (Specify if you pay rent to the person you are living with)

Own \_\_\_\_\_ Rent \_\_\_\_\_ Motel \_\_\_\_\_ Shelter \_\_\_\_\_ Friends \_\_\_\_\_ Relative-Who? \_\_\_\_\_ Other (specify) \_\_\_\_\_ Homeless \_\_\_\_\_

Do you receive WIC? **Y / N** Do you receive food stamps? **Y / N** Does the household have reliable transportation? **Y / N**

Is parent/guardian currently working? Mom/Guardian #1: **FT PT N/A** Dad/Guardian #2: **FT PT N/A**

Is parent/guardian currently enrolled in school? Mom/Guardian #1: **FT PT N/A** Dad/Guardian #2: **FT PT N/A**

For Office Use Only	
Date Accepted	_____
Date Of Entry	_____
EHS Homebased	_____
H.S.-Jeff.	_____
H.S.-W.C.H.	_____
RAB (EHS-CCP)	_____
RAB (Daycare)	_____
Sunrise Sunset	_____
Wilson	_____
Income Verified:	
Under	_____
Over	_____
Points	_____
SSI/TANF	_____
Homeless	_____
Foster	_____
Child's year in program	
1 <sup>st</sup>	2 <sup>nd</sup> 3 <sup>rd</sup>

Names of <b>Siblings</b> in the home:	Birth date	Race	Relationship to child (brother or sister)	Last grade completed
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
Names of <b>Parents/Guardian</b> in home:				
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____

Does child currently have health insurance? **Y / N** Medical insurance name: \_\_\_\_\_

Do you currently receive cash benefits (TANF/OWF) from ODJFS? **Y / N** In the past 12 months? **Y / N**

How did you find out about Head Start? (Flyer/parent/friend/former H.S. child or sibling/referral/returnee/social media) \_\_\_\_\_

**The following questions apply to biological parents and/or current household members:**

Current or history of domestic violence? **Y / N** One or more parents currently or previously incarcerated? **Y / N**

Current or previous case with Children's Services? **Y / N** Current or history of substance abuse? **Y / N**

Does child have a deceased biological parent? **Y / N** Current or history of mental health? **Y / N**

**I certify that this information is true. If any part is false, my participation in this agency's program may be terminated and may be subject to legal action. I understand that the information in 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:	
Date Received	_____
By	_____