# 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

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

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 food stamps? Y / N** Do you receive WIC? **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**

Is parent/guardian an active member of the US military or a veteran?

Mom/Guardian #1: **ACTIVE VETERAN N/A** Dad/Guardian #2: **ACTIVE VETERAN N/A**

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