# Head Start
# 2018-2019 Enrollment Application

St Johns County School District Head Start provides a free pre-school program and comprehensive health and social services to eligible three and four year old children and their families living in St. Johns County.

**Please complete the application completely and accurately. All information will be kept strictly confidential. It will be used to help determine whether or not your family is eligible for Head Start and to prioritize your application. If you need assistance in completing the application you may contact the Head Start office at (904) 547-8965.**

Applications will be processed when all required documents are provided along with the completed application. Required documents:

| | |
|---|---|
| **Certified Birth Certificate** | Available at the Office of Vital Statistics at the Florida Department of Health in St. Johns County or from the county/state that the child was born |
| **Two Proofs of Residency** | Acceptable documents include driver's license, state issued ID, utility bill, lease or rental agreement |
| **Income** | Proof of income for the past year or the past 12 months:<br>12 month pay verification, W2, tax record, benefits award letter, employer verification letter, or child support statement |
| **Photo Identification** | Driver's license, state issued ID, passport, or military ID |

**General Information:** Only a parent or legal guardian may sign this application. Please provide accurate and up-to-date phone numbers and contact information.

**Eligibility:** Documentation of income and eligibility requirements must be provided to complete your application. If your child is in Foster Care, he or she is categorically eligible, and income verification is not required. Documentation of eligibility is required.

**Priority:** Head Start does not process applications based on a first come-first served basis. All applicants are placed on a waitlist. Information provided to us will determine your child's placement on the waitlist.

**Enrollment:** Initial selection occurs during the first week in June. Applications received prior to that date will be considered for initial enrollment. Applications received after June 1st will be placed on the Head Start waitlist.

# Family Member Information

How did you hear about Head Start? _____

**Primary Parent or Guardian:**

First Name: _____ Last Name:_____ Birth Date: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Contact Phone Number (circle one) Home Work Cell

Email Address: _____

Race: (check all that apply)

□ Black □ White □ Multi-racial/Bi-racial □ Asian □ Native American

□ Pacific Islander □ Other _____

Ethnicity:

□ Hispanic □ Non-Hispanic

Highest Grade Completed: _____ Graduated/GED? Yes No

Are you currently a student? □ Yes □ No If yes, where _____

Employment Status: □ Full Time □ Part Time □ Seasonal □ Unemployed □ Retired

Place of employment (if applicable): _____

Relationship to child: _____ Custody of child □ yes □no

Age of parent at first child's birth _____

Primary language of this adult family member: □ English □ Spanish □ Other _____

Primary Caregiver: □ Lives with family □ Provides Financial Support □ Teen Parent
(check all that apply)

Do you currently have health insurance coverage for yourself? Yes No

If yes, with whom _____

**Other Parent or Guardian:** (additional forms available for adding parents/guardians)

First Name: _____ Last Name:_____ Birth Date:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Contact Phone Number (circle one) Home Work Cell

Email Address: _____

Race: (check all that apply)

□ Black □ White □ Multi-racial/Bi-racial □ Asian □ Native American

□ Pacific Islander □ Other _____

Ethnicity:

□ Hispanic □ Non-Hispanic

Highest Grade Completed: _____ Graduated/GED? yes no

Are you currently a student? □yes □ no If yes, where _____

Employment Status: □ Full Time □ Part Time □ Seasonal □ Unemployed □ Retired

Place of employment (if applicable): _____

Relationship to child: _____ Custody of child □ yes □ no

Age of parent at first child's birth _____

Primary language of this adult family member: □ English □ Spanish □ Other _____

Secondary Caregiver: □ Lives with family □ Provides Financial Support □ Teen Parent
(Check all that apply)

Office Use Only:

**Child Information:** (Head Start age eligible child)

First Name: _____ Last Name: _____ Nickname: _____

Birth Date: _____ Gender: □ Male □ Female

Child lives with:

_____Two parents

_____ Single mother _____ Single mother living with partner

_____ Single father _____ Single father living with partner

_____ Parent(s) living with relatives _____ Guardian – documentation required

_____ Foster family – documentation required

_____ Other (specify) _____

Race: (check all that apply)

□ Black □ White □ Multi-racial/Bi-racial □ Asian

□ Native American □ Pacific Islander □ Other _____

Ethnicity: □ Hispanic □ Non-Hispanic

Primary Language: □ English □ Spanish □ Other _____

Insurance Type □ Private □ Medicaid □Military □ Other _____

Has your child had a recent physical exam? Yes No If so, Month/Year _____

Child's Doctor: _____ Phone: _____

Child's Dentist: _____ Phone: _____

Dental Plan: □ Medicaid □ Private _____ □ Other _____

**St. Johns County School District does not provide transportation for Head Start Students.**

How will this child get to/from school? □ parent □ childcare □ other _____

## Other Family Members

In order to determine if your family income is at or below the Federal Poverty Guidelines, we must know how many people are in your family as well as your total family income. For our purposes, a family is "…all persons living in the same household who are (1) supported by the income of the parent(s) or guardian(s) of the child enrolling in the program, and (2) related to the parent(s) or guardian(s) by blood, marriage, or adoption".

**Please list all people in the household who are supported by the parent(s) or guardian(s) applying for Head Start.**

| Name | Birth Date | Gender | Relationship to Parent/Guardian |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |

# Family Information

## General Household Information:

Living Address: _____ _____ _____
street city zip

Mailing Address: _____ _____ _____
street city zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Number in Household _____ Number in Family _____ Total number of children _____

Number of children age 0-3 _____ Number of children age 4-5 _____

Primary Language at Home: □ English □ Spanish □ Other _____

**TANF** □ yes □ no □ formerly **SSI** □ yes □ no

**EBT/ Food Assistance** □ yes □ no **WIC** □ yes □ no

**Episcopal Children's Services** □ yes □ no

Other agencies providing services to your child/family:
_____

**Do you receive Child Support?** □yes □ no

**If yes, how much in the past 12 months? _____**

**Emergency Contacts** (other than parent/guardian)

| | |
|---|---|
| Name: | Relationship to child: |
| Address: | Home phone number: |
| City: State: Zip: | Cell phone number: |
| | Work phone number: |
| □ □ **Emergency Contact** | □ □ **Child may be released to this person** |

| | |
|---|---|
| Name: | Relationship to child: |
| Address: | Home phone number: |
| City: State: Zip: | Cell phone number: |
| | Work phone number: |
| □ □ **Emergency Contact** | □ □ **Child may be released to this person** |

| | |
|---|---|
| Name: | Relationship to child: |
| Address: | Home phone number: |
| City: State: Zip: | Cell phone number: |
| | Work phone number: |
| □ □ **Emergency Contact** | □ □ **Child may be released to this person** |

Office Use Only:

# Priority

**The following information will determine your child's eligibility priority. This information is maintained in your child's confidential application file. Please check all that apply.**

**Diagnosed** issues currently affecting your child:

- □ ADHD / ADD
- □ Hearing Impairment
- □ Asthma (requiring medication)
- □ Heart Condition
- □ Visual Impairment
- □ Diabetes
- □ Severe Tooth Decay
- □ Speech / Language Delay
- □ Emotional / Behavioral Disorder
- □ Developmental Delay
- □ Autism
- □ Seizure Disorder (requiring medication)
- □ Other _____
- □ None

Do you **suspect** any of the above issues to be affecting your child: □ Yes □ No

Please explain: _____

Do you suspect any **other issues** to be affecting your child: □ Yes □ No

Please explain: _____

**Environmental** issues currently affecting your child:

- □ Child Abuse & Neglect
- □ Domestic Violence
- □ Drug or Alcohol Abuse
- □ Divorce (within past 24 months)
- □ Incarceration of a parent
- □ Disabled Parent/Guardian (receiving benefits)
- □ Parent Active Duty Military (out of home)
- □ Teen Parent (previously or currently)
- □ Death of immediate family member (within 24 months)
- □ Receiving services through DCF (foster care, protective services, Family Integrity Program, etc.)
- □ Homelessness (includes families living temporarily in shelters, hotels, or vehicles or moving frequently between the homes of relatives and friends)
- □ Other issues (pregnancy, previous homelessness, family health concerns, etc.)

Please explain: _____

**Truth Statement**

I certify that the information I have provided is true. I also understand that the information provided in this application will be held in the strictest confidence within the St. Johns County School District and is accessible to me by appointment during normal business hours.

I authorize Head Start to verify my family income and circumstances with my employer or other agency, if necessary. I understand that if I deliberately misrepresent my family income or circumstances, my family may not be eligible for further services.

_____ _____

Parent/Guardian Signature Date

Office Use Only:

School Zone: _____

Head Start Site: _____

Date Application Received: _____ Received by: _____