

Head Start 2024-2025 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 determine if 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) 547-8957.

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, mortgage statement.

Eligibility **Proof of income for the past year or the past 12 months:**
12 month pay subs, W2, tax return, W9, child support payments, etc.

Or

Proof of Public Assistance: SSI, TANAF or SNAP

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

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
 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 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.

	<u>Name</u>	<u>Birth Date</u>	<u>Gender</u>	<u>Relationship to Parent/Guardian</u>	<u>Race</u>
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 _____

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:
<input type="checkbox"/> <input type="checkbox"/> Emergency Contact	<input type="checkbox"/> <input type="checkbox"/> Child may be released to this person

Name:	Relationship to child:
Address:	Home phone number:
City: State: Zip:	Cell phone number:
	Work phone number:
<input type="checkbox"/> <input type="checkbox"/> Emergency Contact	<input type="checkbox"/> <input type="checkbox"/> Child may be released to this person

Name:	Relationship to child:
Address:	Home phone number:
City: State: Zip:	Cell phone number:
	Work phone number:
<input type="checkbox"/> <input type="checkbox"/> Emergency Contact	<input type="checkbox"/> <input type="checkbox"/> 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:

- | | | |
|--|--|--|
| <input type="checkbox"/> ADHD / ADD | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Asthma (requiring medication) |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Visual Impairment | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Severe Tooth Decay | <input type="checkbox"/> Speech / Language Delay | <input type="checkbox"/> Emotional / Behavioral Disorder |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Autism | |
| <input type="checkbox"/> Seizure Disorder (requiring medication) | | |
| <input type="checkbox"/> Other _____ | | <input type="checkbox"/> 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:

- | | |
|--|--|
| <input type="checkbox"/> Child Abuse & Neglect | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Drug or Alcohol Abuse | <input type="checkbox"/> Divorce (within past 24 months) |
| <input type="checkbox"/> Incarceration of a parent | <input type="checkbox"/> Disabled Parent/Guardian (receiving benefits) |
| <input type="checkbox"/> Parent Active Duty Military (out of home) | <input type="checkbox"/> 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: _____

Requested School Site (see above) _____

Date Application Received: _____ Received by: _____