SWCAP Head Start/Early Head Start

212 E. Chapel St.
Dodgeville, WI 53533
1-800-494-8899
(608) 935-3379

Date _____
Initial _____
Income _____
E/O $ _____

Child's Information

Child's full name: _____ DOB: _____ Male/Female
First Last MI

Race (circle one): American Indian or Alaska Native Asian Black or African American White
Native Hawaiian or other Pacific Islander Bi-Racial or Multi-Racial Other:_____
Ethnicity (check one): ___ Hispanic or Latino Origin ___Non-Hispanic/Non-Latino

Primary Language: _____ Secondary Language: _____ School District: _____

Child lives with (check all that apply): Mother_____ Father_____ Stepmother_____ Stepfather_____
Foster parent_____ Grandparent_____ Other: _____

Address and Phone

Mailing Address: _____ Living Address (if different): _____

City, State, Zip: _____ City, State, Zip: _____

County: _____ County: _____

Home Telephone: ( ) _____ Other Telephone: ( )_____

Family Information

Head of Household (HOH):_____

Mother's name (if in the home): _____ DOB: _____ If pregnant, due date: _____
Highest grade completed in school (circle one): 9 10 11 12 HSG (high school graduate) GED/HSED
COL (college degree or Associate degree)
Mother works: Full Time_____ Part Time_____ Seasonal_____ Unemployed _____ Disabled_____
Works and attends school_____ Attends School_____

Father's name (if in the home): _____ DOB: _____
Highest grade completed in school: 9 10 11 12 HSG (high school graduate) GED/HSED
COL (college degree or Associate degree)
Father works: Full Time_____ Part Time_____ Seasonal_____ Unemployed_____ Disabled_____
Works and attends School_____ Attends School_____

Other Guardian**:**_____ DOB:_____

List <u>ALL</u> family members living in household:

First & Last Name	Date of Birth	First & Last Name	Date of Birth
_____	M/F ___/____/____	_____	M/F ___/____/____
_____	M/F ___/____/____	_____	M/F ___/____/____
_____	M/F ___/____/____	_____	M/F ___/____/____
_____	M/F ___/____/____	_____	M/F ___/____/____

Are you available during the day for home visits? (Please list time available)_____

Were you referred to Head Start? YES NO If yes by whom?_____

Is child receiving services from: ___Early Childhood ___Birth to Three ___Speech ___Physical Therapy ___Occupational Therapy ___Other preschool program

Medicaid eligibility status: ___Receiving ___Not Receiving

I understand that in order to be enrolled in Head Start, I must participate with my child in physical, dental, and nutritional assessments. I also understand that the information on this application will be held in strict confidence within the agency. I believe all information on this application to be true to the best of my knowledge.

_____ _____

Signature of Applicant **Date**

Mail completed form to: **SWCAP Head Start, 212 E. Chapel St., Dodgeville, WI 53533**

FOR OFFICE USE ONLY

ELIGIBILITY INCOME INFORMATION OF PARENT(S) OR GUARDIAN(S):

Check if any of the following categories apply to family:

_____SSI ____Homeless _____Foster Care ____ Receiving TANF (Kinship/WI Shares/Child Care Assistance/W-2) Circle one

(If any of the above categories apply to family, no other income verification is needed) .

Earned Income:

Weekly: _____ or Biweekly Amount: _____

Year-To-Date (previous 12 months): _____

Monthly Amount: _____

Annual Income (W-2/Income Tax): _____

Other Income:

Child Support_____ Monthly Amount:_____

Other:_____ Monthly Amount:_____

Unemployment____ Weekly Amount:_____

_____ **No Income** (Attach Form 22.SOC)

DOCUMENTS REVIEWED TO VERIFY INCOME:

_____ Income Tax Form _____ Check Stub _____ SSI _____ W-2 Tax Form _____ Verified by Employer

_____ Unemployment Compensation _____ TANF Benefit Other: _____

_____ Documentation of No Income/Homeless (Attach Form 22.SOC)

in Household _____ Total Verified Annual Income: _____

Eligibility: _____O _____E _____PY _____Preschool Head Start _____Early Head Start

_____ _____

Signature of Head Start Staff Receiving Application Date

I attest to the accuracy of the income statement or public assistance documentation stated above.