

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:

Other Income:

Weekly: _____ or Biweekly Amount: _____

Child Support _____ Monthly Amount: _____

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

Other: _____ Monthly Amount: _____

Monthly Amount: _____

Unemployment _____ Weekly Amount: _____

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

_____ **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.