

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: _____

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 ALL 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):

Public Assistance:

___ Receiving TANF (Kinship/Foster Child/WI Shares Child Care Assistance/W-2) circle which apply ___ Receiving SSI

(If family is receiving public assistance, 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: _____

DOCUMENTS REVIEWED TO VERIFY INCOME:

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

___ Unemployment Compensation ___ TANF Benefit Other: _____

Signature of Head Start Staff Receiving Application

Date

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

in Household _____ Total Verified Annual Income: _____

Eligibility: ___ O ___ E ___ PY ___ Preschool Head Start ___ Early Head Start