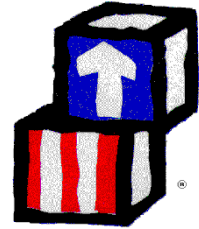


HEAD START of LANE COUNTY and EARLY HEAD START

221 B Street, Springfield OR 97477-4522

(541) 747-2425 · FAX (541) 747-6648 · <http://www.hsolc.org>

"Ensuring that our youngest children have a solid foundation for life."



Eligibility Application (Rev 2/11)

Please fill in the form completely and accurately. All information will be kept confidential. It will be used to help us determine if your family is eligible for Head Start services and to prioritize your placement on the waiting list.

If you have any questions about this application, or need any help in completing it, please call us at 747-2425 ext 1200 for the Receptionist. **We will be glad to help!**

For Pregnant Applicants:

Pregnant Applicant Name: _____ Due Date: _____

For Child Applicants:

Child's Name: _____ Date of Birth: _____
(First, Middle, Last) **(PLEASE ATTACH VERIFICATION: birth certificate, hospital documentation, etc.)**

Sex: Male Female

What language does your child speak most fluently: ... English Spanish Other _____

What other language does your child speak: English Spanish Other _____

Parent or Guardian Information *(The person signing the application should complete this section.)*

Parent or Guardian's Name: _____
(First, Middle, Last)

Date of Birth: _____ Relationship to Child: _____
(Example: Mother, Father, Foster Father, Grandmother, etc.)

Home: _____
(Address) (City) (ZIP)

Mail *(if different)*: _____
(Address) (City) (ZIP)

Telephone: _____
(Home) (Work) (Message)

E-mail address _____

In what language do you prefer to communicate: English Spanish Other _____

Other Parent or Guardian Information

Parent or Guardian's Name: _____
(First, Middle, Last)

Date of Birth: _____ Relationship to Child: _____
(Example: Mother, Father, Foster Father, Grandmother, etc.)

Home: _____
(Address) (City) (ZIP)

Mail *(if different)*: _____
(Address) (City) (ZIP)

Telephone: _____
(Home) (Work) (Message)

E-mail address _____

In what language do you prefer to communicate: English Spanish Other _____

Family Size and Income

By law, Head Start of Lane County may provide services only to families: (1) with a family income at or below the Federal poverty guidelines; (2) who are receiving certain forms of public assistance; (3) who are applying on behalf of a foster child; (4) who are currently homeless. Head Start of Lane County may also serve a limited number of families with special needs who would not otherwise qualify for the program.

Family Size

In order to determine if your family income is at or below the Federal poverty guidelines, we must know how many people are living in your household, as well as your 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 (including the child being applied for) who are supported by the income listed below. (If you need more room, use another sheet of paper.)

	Name (First, Middle, Last)	Relationship to Child	Date of Birth
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____

Automatic Eligibility

Is your family **currently** receiving TANF benefits?..... Yes No

(TANF benefits include on-going TANF cash grant, Assessment Program, ERDC and Retention Activities and Services.

Not included are Food Stamps, OHP Medical Card or Emergency Assistance.)

Please provide your Social Security Number: _____ or proof that you are currently receiving TANF benefits.

Are you or anyone in your family **currently** receiving Supplemental Security Income (SSI)? .. Yes No

(If you have any questions about the type of Social Security you are receiving, please call the Social Security Office at

1-800-772-1213.)

Is this application for a foster child placed with you through the State of Oregon? Yes No

Is your family **currently** Homeless?..... Yes No

(living temporarily in shelters, hotels, or vehicles; or moving frequently between the homes of relatives and friends)

If you answered "Yes" to any of the above, you are automatically income eligible for Head Start services. You may be asked to provide verification(s). Go to the next page.

Family Income

Income *(see definition below)* must include the total income of all members of the family listed above for either the past twelve months or for the previous calendar year, whichever more accurately reflects your family's current situation.

I HAVE ENCLOSED ONE OF THE FOLLOWING REQUIRED DOCUMENTS FOR INCOME VERIFICATION

- | | |
|--|---|
| <input type="checkbox"/> Pay Stubs (12 months) | <input type="checkbox"/> Individual Income Tax form 1040 <i>(expanded 1040)</i> |
| <input type="checkbox"/> W-2 Forms | <input type="checkbox"/> Written Statement From Employer / Pay Envelopes |

I HAVE ENCLOSED ONE OF THE FOLLOWING ADDITIONAL TYPES OF INCOME VERIFICATION

- | | |
|---|---|
| <input type="checkbox"/> Unemployment Information | <input type="checkbox"/> Child Support Information |
| <input type="checkbox"/> Social Security Benefits | <input type="checkbox"/> Financial Aid Award Letter |

HEAD START PROGRAM DEFINITION OF INCOME: Income means total cash receipts before taxes from all sources, with certain exceptions. Income includes: (1) money, wages or salary before deductions; (2) net income from non-farm or farm self-employment; (3) social security or railroad retirement; (4) unemployment compensation, strike benefits, workers' compensation, veterans benefits, or public assistance; (5) training stipends; (6) alimony, child support, military family allotments, other regular support from absent family member or someone not living in the household; (7) private pensions, government pensions including military retirement, insurance or annuity payments; (8) college scholarships, grants, fellowships, assistantships; (9) dividends, interest, net rental income, net royalties, receipts from estates or trusts; (10) net gambling or lottery winnings.

Other Assistance

Are you currently receiving assistance from any other agency? *(please check all that apply)*

Energy Assistance Food Stamps Subsidized Housing (Low-income; Section 8)

Is your child currently receiving medical or dental coverage through Oregon Health Plan (OHP)? Yes No

Priority

The following information will be used to prioritize your placement on the waiting list.

Please check all that apply.

DIAGNOSED MEDICAL OR BIOLOGICAL ISSUES

Please indicate any diagnosed medical or biological issues currently affecting your child.

- | | |
|---|---|
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Heart condition |
| <input type="checkbox"/> Asthma <i>(requiring medication)</i> | <input type="checkbox"/> Seizure disorder <i>(requiring medication)</i> |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Traumatic brain injury |
| <input type="checkbox"/> Eczema <i>(requiring medication)</i> | <input type="checkbox"/> Visual impairment |
| <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Other |
-

DIAGNOSED DISABILITIES

To provide the best placement for your child, please indicate any disabilities that have been diagnosed for which your child is receiving Early Childhood Special Education Services.

- | | |
|---|--|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Emotional/behavioral disorder |
| <input type="checkbox"/> Communication disorder | <input type="checkbox"/> Orthopedic impairment |
| <input type="checkbox"/> Developmental delay | |

Signature required to exchange information with Early Childhood CARES _____

FAMILY CIRCUMSTANCES

Please indicate any issues which have occurred to your child's immediate family.

WITHIN THE LAST 2 YEARS (24 months)

- Child abuse or neglect
- Death in the family
- Divorce
- Domestic violence
- Drug or alcohol abuse
- Incarceration of a parent or guardian
- Migrant Worker
- Homelessness *(includes families living temporarily in shelters, hotels, or vehicles; or moving frequently between the homes of relatives and friends)*

CURRENTLY

- Parent or guardian needs an Interpreter
 - Child is in foster care, and was placed with you by the State of Oregon
 - Child is not in foster care, but is not living with a biological or adoptive parent
 - Only one adult lives in the home
 - Military deployment
 - Parent or guardian is receiving disability payments *(please provide proof)*
 - Other
-

SPECIAL CIRCUMSTANCES

If you would like to be considered for Head Start even though you may not otherwise qualify, please describe the special challenges and circumstances of your family.

Program Options

Please review the program options below and indicate which would best meet your family's needs.

Early Head Start Program / 12 months

Are you applying for Early Head Start? Yes No

Full-Day Program / 12 months

Are you applying for Full Day? Yes No

- Designed for working parents and students **who qualify and need childcare services**
- Transportation is **not** provided
- Home visits throughout the year
- Typically open Monday- Friday 7:30-5:30

Are you working?..... Yes .. No Do you have employment-related day care (ERDC)? .. Yes No

Are you going to school?..... Yes .. No Do you receive financial aid for school? Yes No

Are you in the jobs program? Yes No

Do you need childcare for more than 3½ hours a day? Yes No

If you answered "Yes" to any of the above, you may be eligible for Head Start services at a Full Day Site or Community Childcare Center.

PLEASE PROVIDE VERIFICATION (Statement from DHS showing childcare hours and co-pay amount, current year financial aid award letter, etc.)

Part-Day Program / 9 months

Are you applying for Part Day? Yes No

- 3½ hour days, Tuesday – Friday, AM or PM
- Limited transportation available
- Home visits throughout the year

Can you provide transportation for your child to attend? Yes No

Do you need transportation to other than your home address? Yes No

• The address you would need your child picked up at _____

• The address you would need your child dropped off at _____

Affirmation

Under penalty of perjury, I affirm that I am the parent or legal guardian of the child applying for Head Start, and that, to the best of my knowledge, all of the information that I have provided is complete and correct. I understand that if I deliberately misrepresent my family circumstances, my family may not be eligible for further services.

I authorize Head Start to verify my family income and circumstances with the Oregon Department of Human Services (DHS) and with my employer, if necessary.

Parent or Guardian Signature

Social Security Number (not required)

Date Signed

Head Start of Lane County does not discriminate against children or families on the basis of race, color, national origin, gender, religion, age, disability, political beliefs, sexual orientation, and marital or family status.

For Office Use Only

Date received: _____

WebCAF #: _____

Staff Signature: _____

Date: _____