LUTHERAN SERVICE FLORIDA, INC
HEAD START/EARLY HEAD START PROGRAM
ENROLLMENT APPLICATION

Applying for: ☐ **Head Start** ☐ **Early Head Start**

Date Received: **Enrollment Date:**

CHILD INFORMATION

School/Center:

Last Name:	**First Name:**	**Date of Birth:**	**Gender:** ☐ Male ☐ Female

Language Spoken at Home: ☐English ☐Spanish ☐Creole ☐Other _____ **Interpreter needed:** ☐Yes ☐No

Race: ☐Black/ African-American ☐White ☐Asian ☐American Indian/ Alaska Native ☐Multi-racial/ Bi-racial ☐Native Hawaiian/ Other Pacific Islander ☐Other

Ethnicity: ☐Hispanic/ Latino ☐Non-Hispanic/ Non-Latino

Was the child referred to Head Start by another Agency? ☐No ☐Yes

If yes, describe: _____

PARENTS' INFORMATION

First and Last Name	Lives with the child	Date of Birth	Race	Language Spoken	Last Grade Completed	Hours Worked	Occupation
Mother							
Father							
Guardian **Relationship to Child: (Check One)** ☐Foster ☐Grandparent ☐Other Relative ☐Other _____							

Living Address: City: Zip Code: Apt # Lot # Unit #

Mailing Address: City: Zip Code: Apt # Lot # Unit #

My Living Address is: [ ] My own Residence [ ] Living with Relative/Friends [ ] Other _____ **Parent Military Deployment** ☐ Yes ☐ No

Mother's Phone #: _____/_____/_____ **Father's Phone #:** _____/_____/_____
Home **Cell** **Other** **Home** **Cell** **Other**

Mother/Guardian Employer's Name: _____ **Work #** _____ **City** _____ **Zip Code** _____

Father/Guardian Employer's Name: _____ **Work #** _____ **City**_____ **Zip Code** _____

Parent Status (in household): ☐One ☐Two ☐Legal Guardian ☐Foster **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Number in Family:_____ **Number of Family Members you Support**: _____ **Have you ever had a child in HS/EHS?** ☐ Yes ☐ No

How did you hear about Head Start? ☐Word of Mouth ☐Family/ Friend ☐Newspaper ☐Radio ☐Community Agency ☐Website ☐Flyer ☐Former/Current HS Parent

OTHER FAMILY MEMBERS IN HOUSEHOLD YOU SUPPORT

First & Last Name	Date of Birth	Sex	Relationship to the Child	Child or Adult	Is the adult an "Authorized Caregiver" & Provides Support?	
		M F			NO	YES
		M F			NO	YES
		M F			NO	YES
		M F			NO	YES
		M F			NO	YES
		M F			NO	YES

EMERGENCY CONTACT INFORMATION & PERSON(s) AUTHORIZED TO PICK UP CHILD FROM THE SCHOOL/CENTER

Name of Adult	Address	Phone	Relationship

TURN OVER TO COMPLETE APPLICATION **OVER →→→**

CHILD'S DISABILITIES INFORMATION

Disability Status: ☐Diagnosed ☐Suspected/Concern ☐None **Please provide documentation:** ☐IEP ☐IFSP ☐Evaluation/Doctors Note

Does your child have concerns in the following areas: ☐Vision ☐Developmental ☐Hearing ☐Speech ☐ Other_____

CHILD'S MEDICAL INFORMATION

Medical Diagnosis: _____ **Any prescribed medication(s)?**_____

☐Diagnosed Asthma ☐Diagnosed Allergies (Food, Insect, Environmental) ☐Other _____

Medical Concern(s) _____ **Nutrition Concern(s):** ☐Yes ☐ No **Special Diet:** _____

Medicaid Status: ☐Eligible ☐Ineligible ☐Applied ☐Former **Medicaid #** _____

Medical Insurance: ☐Private ☐S-CHIP **Medical Insurance #:**_____ **Medical Provider:** _____

Dental Insurance: ☐Yes ☐No **Dental Insurance #:** _____ **Dental Provider:** _____

Any specific family need or crisis? ☐ No ☐ Yes (If yes, describe)

GROSS INCOME - BEFORE TAXES AND DEDUCTIONS ARE SUBTRACTED

MOTHER/LEGAL GUARDIAN/RELATIVE CAREGIVER:

Employed ☐ Yes ☐ No ☐ Full Time ☐ Part Time **Gross Income:** $ _____ **Paid:** ____Weekly ____Biweekly ____ Monthly

Attends School (Name): _____ **Student Status:** ☐ Full Time ☐ Part Time

FATHER/LEGAL GUARDIAN/RELATIVE CAREGIVER:

Employed ☐ Yes ☐ No ☐ Full Time ☐ Part Time **Gross Income:** $ _____ **Paid:** ____Weekly ____Biweekly ____ Monthly

Attends School (Name): _____ **Student Status:** ☐ Full Time ☐ Part Time

OTHER GROSS INCOME (DOCUMENTS REQUIRED)	GROSS INCOME ADJUSTMENT CALCULATION – (HOUSING COST) (DOCUMENTS REQUIRED)
Business Income (self-employed): $_____ **Other Income: $**_____ **Unemployment Compensation $** _____ (Weekly/ Biweekly/ Monthly) **Pension/Annuity Payments: $**_____ **Military Income: $**_____	**Total annual applicable expenses on housing** Rent/Mortgage Payments: $_____ Homeowner/Rental Insurance: $ _____ Home Interest/ Taxes: $_____ Utilities: Electric: $_____ Water: $_____ Gas: $_____ Sewer/Trash: $_____

PLEASE READ BEFORE SIGNING:

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT ALL INCOME IS REPORTED. I UNDERSTAND THAT THIS INFORMATION IS BEING GIVEN TO DETERMINE ELIGIBILITY FOR A FEDERAL PROGRAM AND WILL BE VERIFIED FOR ACCURACY. I UNDERSTAND THAT DELIBERATE MISREPRESENTATION OF THE INFORMATION MAY SUBJECT ME TO WITHDRAWAL FROM THE PROGRAM AND PROSECUTION UNDER APPLICABLE STATE AND FEDERAL LAWS.

Parent Signature: _____ **Date:** _____

E-mail Address:_____

IN ACCORDANCE WITH THE AMERICANS WITH DISABILITIES ACT, THIS PROGRAM DOES NOT DISCRIMINATE BASED ON DISABILITY.

!!! STOP !!!

DO NOT WRITE IN THIS AREA -- FOR OFFICE USE ONLY

Application Accepted By:

ELIGIBILITY DETERMINATION RECORD

DESCRIPTION	(PTS)	DESCRIPTION	(PTS)	
Parental Status:		Disability:		☐ In-Person Interview
Income:		Family Risk and Other Factors:		☐ Audio or Video Interview
Age:		Health Risk Factors:		**Total Points:**

Eligibility Comments:

TOTAL GROSS INCOME (Documented)	TOTAL OTHER INCOME (Documented)	CRITERIA ENROLLED UNDER
COMPUTED IN ONE OF THE FOLLOWING WAYS: PREVIOUS 12 MONTHS / CALENDAR YEAR INCOME		
Mother's Income: $_____ **Doc.**_____ **Father's Income: $** _____ **Doc.**_____ **Guardian's Income: $**_____ **Doc.**_____ **Total Earned Income: $**_____ **Total Housing Deduction: $**_____ **Total Adjusted Household Income: $**_____ (only use if housing costs are 30% or more of total gross income)	**Business Income: $**_____ **Unemployment: $**_____ **Pension/Annuity: $**_____ **Military Income: $**_____ **Other $** _____ **Source** _____ **Total Other Income: $**_____	____ **A. Age (Documentation**_____**)** ____ **B. Income Eligible (below 100%)** ____ **C. Public Assistance (SNAP, TANF, SSI)** ____ **D. 101%-130%** ____ **E. Foster Care** ____ **F. McKinney-Vento** ____ **G. Over Income**
Gross Income: $	**# in Family:**	**Income Time Frame:**

Documents Reviewed and Verified by: _____ **Date:** _____

(Family & Community Engagement Specialist)

FACE Manager/Supervisor Signature: _____ **Date:** _____