FULMONT COMMUNITY ACTION AGENCY, INC.
EARLY CHILDHOOD SERVICES
HEAD START APPLICATION

PLEASE CALL 1-800-958-8225 TO MAKE ARRANGEMENTS TO HAVE YOUR APPLICATION PICKED UP OR DROPPED OFF AT ONE OF OUR LOCATIONS.

PARENT'S CHECKLIST FOR ENROLLING AT HEAD START:

Please be aware that the following items must be submitted before your child can be accepted: Application completed and signed. All lines must be filled out completely or marked "does not apply" (NA)

- *Income (Below is a list of acceptable proof of income for one year):*
  - *Tax return*
  - *Last pay stubs of the year outlining your year to date salary*
  - *Employer statements on letter head outlining your annual income for the previous year*
  - *TANF printout*
  - *SNAP printout*
  - *SSI printout*
  - *Disability printout*
  - *Social Security*
  - *Unemployment printout*
  - *Child support (either court order or notarized letter stating amount received)*
  - *Rental income*
  - *If you were not employed, you must submit a notarized letter stating the time period you were not employed.*
- *Copy of child's birth certificate*
- *Copy of child's immunization record*

All information is kept confidential

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Child's Full name: _____ Date of Birth:_____

Gender: ☐ Female ☐ Male Primary Language: _____ Other Language: _____

Public School District: _____

Family Type:	**Parental Status:**
☐ Single Parent ☐ Two Parents ☐ Foster Parent ☐ Formal Custody	☐ Married ☐ Separated ☐ Single ☐ Divorced

Parent/Guardian Name: _____ Date of Birth: _____

Cell Phone #: _____ Home #: _____ Email address: _____

Primary Address: _____

Employed: ☐ Yes ☐ No If yes, Place of Employment _____ Phone # _____

Primary Language: _____ Other Language: _____ Which language do you read and write: _____

Parent/Guardian Name: _____ Date of Birth: _____

Cell Phone #: _____ Home #: _____ Email address: _____

Primary Address: _____

Employed: ☐ Yes ☐ No If yes, Place of Employment _____ Phone # _____

Primary Language: _____ Other Language: _____ Which language do you read and write: _____

Family Services Received:	**Medical Insurance:**	**Type of Insurance:**
☐ TANF ☐ WIC ☐ Food Stamps	☐ Yes ☐ No	☐ Medicaid ☐ Family Health Plus ☐ Military ☐ Private ☐ Combined Medicaid with Fidelis or CDPHP ☐ Other

Does child or any family member have any diagnosed disabilities or health needs? ☐ Yes ☐ No

Name? _____ Describe diagnosed disability/Health need: _____

Name? _____ Describe diagnosed disability/Health need: _____

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How did you hear about Head Start?

☐ Road Sign ☐ Facebook ☐ ECS Staff contacted me ☐ Other _____
☐ Brochure ☐ Community Event ___ by home visit
___ by phone call

Do you have transportation? ☐ Yes ☐ No

Is your family experiencing any present difficulties? ☐ Yes ☐ No If yes, please explain: _____

HOUSEHOLD

Name	Date of Birth	Relationship to child

Is anyone living within the household listed on the NY State Sex Offenders Registry? ☐ Yes ☐ No

If yes, who? _____

Source of Income:

☐ Employment ☐ Child Support ☐ Alimony

☐ Foster Care ☐ Unemployment Benefits

☐ Pension ☐ Other _____

☐ SSI ☐ SSD

Check off all that apply to you or family members:

☐ Deceased Parent ☐ Parent in School/Training

☐ Substance Abuse ☐ Parent in US Military

☐ Incarceration Name? _____

PLEASE CHECK WHICH PROGRAM YOU WOULD LIKE YOUR CHILD TO BE ENROLLED IN:

- ☐ **Amsterdam**
- ☐ **Gloversville**
- ☐ **OESJ**
- ☐ **Johnstown**
- ☐ **Mayfield**

***** I hereby attest that the information collected on this form is true and accurate to the best of my knowledge*****

_____ _____

Applicant Signature ***Date*** ***ECS Staff Signature*** ***Date***