EARLY HEAD START WAITING LIST APPLICATION

DATE: _____

Child's Name: _____ Date of Birth: _____ ___Male ___Female
Mother's Name: _____ Date of Birth: _____
Address: _____ Is this your home? ___ or a temporary living arrangement?____
Phone: _____ Place of Employment: _____ Phone: _____
Are you or your partner pregnant at this time? _____ Due Date: _____
Is this your first pregnancy? (Y) (N) If no, number of other children ____ Other pregnancies? ____
Father's Name: _____ Date of Birth: _____
Does father live with the family? (Y) (N) If no, his address is: _____
Phone: _____ Place of Employment: _____ Phone: _____
Marital Status: _____
Family Income: $_____ *(For Qualification Purposes, can include current pay stub tax information)*

Please fill out parental information if under 18

Mother's Name: _____ Home Phone: _____
Address: _____ Message Phone: _____
_____ Work Phone: _____

Father's Name: _____ Home Phone: _____
Address: _____ Message Phone: _____
_____ Work Phone: _____

Family Composition:
___ First child in family ___Two parent family ___Single parent ____Foster family
___Minor living alone ___Minor with spouse/significant other ___Single parent with significant other
___Multi generational (parents & grandparents in the same household) ___Other

Please fill out child care information if you have other children
Primary child care provider: _____ Is this a licensed child care provider? (Y)(N)

Other adults lining in the client's home:
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Other children living in the client's home:
Name: _____ DOB: _____ Relationship: _____
Name: _____ DOB: _____ Relationship: _____
Name: _____ DOB: _____ Relationship: _____
Name: _____ DOB: _____ Relationship: _____

Primary language spoken in home: _____

Family Education (check one)
___Father Did Not Complete High School
___ Mother Did Not Complete High School
___ Father Completed GED
___ Mother Completed GED
___ Father Completed High School
___ Mother Completed High School
___Father Completed College
___ Mother Completed College

Is anyone in the family receiving:
___ TANF/POWER/SSI ___ KID Care (Title 19) ___Equality Care (Medicaid) ___Food Stamps ___ WIC
___ Childcare Reimbursement ___ Other_____
___ Child is currently being tested for developmental delays
___Child is on current IFSP

Was the family referred by an agency? (Y) (N) If yes, which agency _____
Reason for referral? _____

Has the child or any member of the immediate family experienced any of the following in the last year?

Family Stress

- ☐ **Divorce**
- ☐ **Marriage**
- ☐ **Incarceration**
- ☐ **Eviction**
- ☐ **Change in # of household members**
- ☐ **Job Loss or Change**
- ☐ **Lives a rural area of Campbell County**
- ☐ **New to Town**
- ☐ **Unplanned Pregnancy**

Social Service Needs

- ☐ **Court mandated services**
- ☐ **Child Abuse**
- ☐ **Family Violence**
- ☐ **Drug or alcohol–abuse**
- ☐ **Parent in re-hab**

Environmental

- ☐ **Lack of appropriate nutrition**
- ☐ **Neglect**
- ☐ **Lack of adequate housing**
- ☐ **Lack of affordable licensed child care**

Health Concerns

- ☐ **Mental Health Concerns/Depression**
- ☐ **Pre-Natal Concerns**
- ☐ **Significant Health Problems**
- ☐ **Applicant lacks affordable and or assessable health and or dental insurance**

Do you have any special concerns? Please explain _____
_____
_____

**************FOR OFFICE USE ONLY************

Staff initials: _____ Date: _____

Comments:

Any referrals made: _____
___Public Health
___Even Start
___Head Start
___CDS-CC for Developmental Screening
Do they qualify for the Public Health Home Visiting Program? _____