ENROLLMENT APPLICATION

City of Oakland Early/Head Start Program
150 Frank H. Ogawa Plaza, Suite 5352
Oakland, CA 94612
(510) 238-3165 / (510) 238-6784 Fax

Please check one: ☑
❑ Early Head Start or ❑ Head Start

PLEASE USE BLUE OR BLACK INK AND PRINT LEGIBLY

Child's Last Name	**First Name**	**Middle Name**

Date of Birth	**Gender** ❑ Female ❑ Male	**Social Security # (optional)** - -

Child's Race (Select all that apply)
❑ Asian ❑ Native Hawaiian or Pacific Islander
❑ Black/African-American ❑ White
❑ American Indian or Alaskan Native ❑ Unspecified

Child's Ethnicity: ❒ Hispanic/Latino ❑ Non-Hispanic

Does Child Speak English? ❑ Yes ❑ No

Child's Doctor (Name/Phone)	**Child's Dentist (Name/Phone)**	**Child's Health Insurance** ❑ Medi-Cal ❑ Healthy Families ❑ Private ❑ None **Medical #:**

How did you hear about Head Start? ❑ Family ❑ Friend ❑ Media ❑ Other (specify)

Primary Parent/Guardian Name (child lives with) *First* *Last*	**Birth Date** / /	**Relationship to child**

Gender ❑ Female ❑ Male	**Social Security #**	**Highest Grade Completed** ❑ Less than HS ❑ Some College, AA Deg. ❑ HS Grad/GED ❑ Bachelor or Adv. Deg.	**Employment Status** ❑ Employed & School ❑ School ❑ Employed ❑ Unemployed

Secondary Parent/Guardian Name (child lives with) *First* *Last*	**Birth date** / /	**Relationship to child**

Gender ❑ Female ❑ Male	**Social Security #**	**Highest Grade Completed** ❑ Less than HS ❑ Some College, AA Deg. ❑ HS Grad/GED ❑ Bachelor or Adv. Deg.	**Employment Status** ❑ Employed & School ❑ School ❑ Employed ❑ Unemployed

Child's Living Address	**City**	**Zip Code**

Home Phone ❑Primary ( )	**Cell Phone** ❑Primary ( )	**Message Phone** ❑Primary ( )

Number in Family	**Number of Children**
Primary Language spoken in the home:	

Parental Status: ❑ Single Parent ❑ Two Parents
Custody Arraignments:
❑ Sole Custody ❑ Joint Custody ❑ Legal Guardianship

FAMILY INCOME INFORMATION: Include all sources of income for each adult living in the home that provides financial support for the child. Types of income include any salary/wages/tips, self-employment, disability, unemployment, worker's compensation, child support and alimony. *(Please attach proof of income for each parent living in the same household.)*

Do you receive TANF or CalWorks? ❑ Yes ❑ No ❑ **Pregnant Mom**; Expected Date of Delivery ____/____/____
Do you receive Supplemental Security Income (SSI)? ❑ Yes ❑ No **Foster Child** ❑ Yes ❑ No
❑ **Currently in Crisis** (Domestic Violence, Death of a Parent, Primary Parent Incarcerated etc.) ❑ **Teen Parent under 19 years old**
Do you receive WIC? ❑ Yes ❑ No WIC #

First and Last Name ***Enter Primary Adult First***	**Relationship to Child**	**Source of Income**	**Amount**	**Frequency Paid (hourly, weekly, 2x Mo, every other week)**
1.				
2.				

FAMILY MEMBER INFORMATION

List all family members who are financially supported by parent or guardian of the applying child and are related by blood, marriage or adoption.

Additional siblings living in the home	**Birth Date**	**Relationship to Child**	**Family Member**	**Gender**
3.			❑ Adult ❑ Child	❑ Male ❑ Female
4.			❑ Adult ❑ Child	❑ Male ❑ Female
5.			❑ Adult ❑ Child	❑ Male ❑ Female
6.			❑ Adult ❑ Child	❑ Male ❑ Female
7.			❑ Adult ❑ Child	❑ Male ❑ Female
8.			❑ Adult ❑ Child	❑ Male ❑ Female

I certify that all the information I provide on this application is accurate to the best of my knowledge.
I understand this information is strictly confidential and will be used to determine eligibility.

Parent/Guardian Signature _____ Date: _____

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Child"s Name: DOB:

Additional Information

Does your child have sibling(s)/family member(s) currently enrolled? ❑ Yes ❑ No **Center(s)-**	**Does your child have a Medical/Health concern/condition that requires special care, i.e., Asthma, Diabetes allergies, etc.?** ❑ No ❑ Yes (Specify)
Are you and the other parent/guardian(s) in need of full day services? ❑ Yes ❑ No ❑ Employed ❑ In School ❑ Job Training (Attach proof of work or school or job training) ***Applies to two parent households only*** **Are both parents/guardians working, in school or job training**? ❑ Yes ❑ No (Attach proof of work or school or job training for both parents)	**Does child have a diagnosed disability or special need with an IEP or IFSP?** ❑ No ❑ Yes (Specify) _____ _____ _____ ___ **(Must attach current copy of IEP or IFSP)**
Housing Status- check all that apply to you or the child: ❒Living in a shelter ❒Living in a car/vehicle ❒ Living with a friend/relative due to economic hardship (Attach Verification)	**Does your family have an active CPS (Child Protective Services) case?** ❑ Yes ❑ No (please attach documentation from social worker)
Where you referred to Head Start/EHS by a community agency? ❑ Yes ❑ No (If so, please attach documentation) **Name of Agency:**	
Are you or the other a Parent/Guardian with a diagnosed disability? ❑ Yes ❑ No *Specify and provide verification:*	
What type of transportation do you use? ❑ Private Vehicle ❑ Family/Friend Vehicle ❑ Public Transportation	
Are you an employee of the Head Start/Early Head Start? ❑ Yes ❑ No Position:	
Are you related to an employee of the Head Start/Early Head Start? ❑ Yes ❑ No	
e-mail address:	

Program Option Preferences: Center Base, Family Child Care or Home Base	**1st Choice** **❑ Center Base ❑ FCC ❑ HB** **Site Name:_____**	**2nd Choice** **❑ Center Base ❑ FCC ❑ HB** **Site Name:_____**	**3rd Choice** **❑ Center Base ❑ FCC ❑ HB** **Site Name:_____**

Non-Discrimination Policy

The Head Start/Early Head Start Program prohibits discrimination in all of its programs and activities on the basis of race, color, national origin, gender, religion, age, disability, sexual orientation, ethnic group identification, ancestry, political beliefs, mental or physical disability, or any legally protected status. The program welcomes children of all abilities including children with special needs. At least 10% of enrollment opportunities are reserved for children with diagnosed special needs.

Early/Head Start Staff Only					
Child's Birth Certificate	Date Rec'd:	By:	Medical Insurance Card	Date Rec'd:	By:
Proof of Income	Date Rec'd:	By:	Custody Papers	Date Rec'd:	By:
Proof of Residency	Date Rec'd:	By:	I.F.S.P. or I.E.P.	Date Rec'd:	By:
Immunization Records	Date Rec'd:	By:	Homeless Verification	Date Rec'd	By:
Application completed with supporting verification at ❑ Center/FCC _____ ❑ Central Office			Receiving Staff's Name:		
Is this an Early Head Start Transition Application ❑ Yes ❑ No			Is this an updated application ❑ Yes ❑ No Today's Date: _____		