

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

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 <input type="checkbox"/> Female <input type="checkbox"/> Male	Social Security # (optional) - -		
Child's Race (Select all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> American Indian or Alaskan Native		Child's Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unspecified		Does Child Speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No
Child's Doctor (Name/Phone)	Child's Dentist (Name/Phone)	Child's Health Insurance <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Healthy Families <input type="checkbox"/> Private <input type="checkbox"/> None Medical #:		
How did you hear about Head Start? <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Media <input type="checkbox"/> Other (specify)				

Primary Parent/Guardian Name (child lives with) First Last		Birth Date / /	Relationship to child
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Social Security #	Highest Grade Completed <input type="checkbox"/> Less than HS <input type="checkbox"/> Some College, AA Deg. <input type="checkbox"/> HS Grad/GED <input type="checkbox"/> Bachelor or Adv. Deg.	Employment Status <input type="checkbox"/> Employed & School <input type="checkbox"/> School <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed
Secondary Parent/Guardian Name (child lives with) First Last		Birth date / /	Relationship to child
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Social Security #	Highest Grade Completed <input type="checkbox"/> Less than HS <input type="checkbox"/> Some College, AA Deg. <input type="checkbox"/> HS Grad/GED <input type="checkbox"/> Bachelor or Adv. Deg.	Employment Status <input type="checkbox"/> Employed & School <input type="checkbox"/> School <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed
Child's Living Address		City	Zip Code
Home Phone <input type="checkbox"/> Primary () ()	Cell Phone <input type="checkbox"/> Primary () ()	Message Phone <input type="checkbox"/> Primary () ()	

Number in Family	Number of Children	Parental Status: <input type="checkbox"/> Single Parent <input type="checkbox"/> Two Parents
Primary Language spoken in the home:		Custody Arrangements: <input type="checkbox"/> Sole Custody <input type="checkbox"/> Joint Custody <input type="checkbox"/> 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 <i>Enter Primary Adult First</i>	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.			<input type="checkbox"/> Adult <input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female
4.			<input type="checkbox"/> Adult <input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female
5.			<input type="checkbox"/> Adult <input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female
6.			<input type="checkbox"/> Adult <input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female
7.			<input type="checkbox"/> Adult <input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female
8.			<input type="checkbox"/> Adult <input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> 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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Early Head Start or Head Start

Child's Name: _____

DOB: _____

Additional Information

Does your child have sibling(s)/family member(s) currently enrolled? <input type="checkbox"/> Yes <input type="checkbox"/> No Center(s)-		Does your child have a Medical/Health concern/condition that requires special care, i.e., Asthma, Diabetes allergies, etc.? <input type="checkbox"/> No <input type="checkbox"/> Yes (Specify)	
Are you and the other parent/guardian(s) in need of full day services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Employed <input type="checkbox"/> In School <input type="checkbox"/> Job Training (Attach proof of work or school or job training)		Does child have a diagnosed disability or special need with an IEP or IFSP? <input type="checkbox"/> No <input type="checkbox"/> Yes (Specify) _____ _____ _____ _____ (Must attach current copy of IEP or IFSP)	
Applies to two parent households only Are both parents/guardians working, in school or job training? <input type="checkbox"/> Yes <input type="checkbox"/> No (Attach proof of work or school or job training for both parents)		Housing Status- check all that apply to you or the child: <input type="checkbox"/> Living in a shelter <input type="checkbox"/> Living in a car/vehicle <input type="checkbox"/> Living with a friend/relative due to economic hardship (Attach Verification)	
Where you referred to Head Start/EHS by a community agency? <input type="checkbox"/> Yes <input type="checkbox"/> No (If so, please attach documentation)		Does your family have an active CPS (Child Protective Services) case? <input type="checkbox"/> Yes <input type="checkbox"/> No (please attach documentation from social worker)	
Name of Agency:			
Are you or the other a Parent/Guardian with a diagnosed disability? <input type="checkbox"/> Yes <input type="checkbox"/> No Specify and provide verification:			
What type of transportation do you use? <input type="checkbox"/> Private Vehicle <input type="checkbox"/> Family/Friend Vehicle <input type="checkbox"/> Public Transportation			
Are you an employee of the Head Start/Early Head Start? <input type="checkbox"/> Yes <input type="checkbox"/> No Position:			
Are you related to an employee of the Head Start/Early Head Start? <input type="checkbox"/> Yes <input type="checkbox"/> No			
e-mail address:			
Program Option Preferences: Center Base, Family Child Care or Home Base	1st Choice <input type="checkbox"/> Center Base <input type="checkbox"/> FCC <input type="checkbox"/> HB Site Name: _____	2nd Choice <input type="checkbox"/> Center Base <input type="checkbox"/> FCC <input type="checkbox"/> HB Site Name: _____	3rd Choice <input type="checkbox"/> Center Base <input type="checkbox"/> FCC <input type="checkbox"/> HB Site Name: _____
Non-Discrimination Policy <i>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.</i>			

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 <input type="checkbox"/> Center/FCC _____ <input type="checkbox"/> Central Office			Receiving Staff's Name:		
Is this an Early Head Start Transition Application <input type="checkbox"/> Yes <input type="checkbox"/> No			Is this an updated application <input type="checkbox"/> Yes <input type="checkbox"/> No Today's Date: _____		