**City of Oakland ♦ Department of Human Services ♦ Head Start Program**
150 Frank H. Ogawa Plaza, Suite 5352, Oakland, CA 94612 (510) 238-3165 (510) 238-6784 fax

# HEAD START ENROLLMENT APPLICATION

**HEAD START CENTER:** _____ Program Year 20_____to 20_____
**(Please print clearly)**

| ♦**Child's Name**: Last First MI | **Child's SS#** - - | **Date of Birth** / / |
|---|---|---|
| **Mother/Guardian's**: Last First | **Mother/Guardian SS#** - - | |
| Address: Apt. City: Zip: | Home/Mess. # ( ) | |
| **Father/Guardian's:** Last First | **Father/Guardian SS#** - - | |
| Address: Apt. City: Zip: | Home/Mess. # ( ) | |

**Family Members Information** ☐ **(Please check box if the back page lists additional family members)**

| Name Last First | Age | Sex M or F | Relationship to Head Start Child? | SS# for family member | Education Level | Annual Income/Source |
|---|---|---|---|---|---|---|
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**# of persons**: Family ( ) Home ( )
**# of children:** Age 0-3 yrs. ( ) 4-5 yrs. ( ) 6+ yrs.( )

♦**Child's Sex:-** M or F

**Primary Language**:
**2nd Language:**

**Health Plan**: (Please check all that apply and write in child's insurance card #)

☐ **No Health Insurance**
☐ Medi-Cal – Provider _____ #_____
☐ Healthy Families – Provider _____ #_____
☐ Private – Provider _____ #_____
☐ Other: (Please specify) _____ #_____

**Race:** (Please check all that apply)
☐ Black/African American
☐ Hispanic or Latino
☐ Native American/Alaska Native
☐ Asian
☐ Native Hawaiian/Pacific Islander
☐ White
☐ Unspecified
☐ Other: _____

**Parental Status**: (Please check one):
☐ One parent ☐ Two parent ☐ Foster Parent ☐ Guardian

**Custody Arraignments:** (Please check)
☐ Joint ☐ Sole ☐ Other:

Is the applicant a sibling of a currently enrolled child? ☐ **No** ☐ **Yes,** Enrolled child's name:_____

**Optional:** Child has disability or special need? ☐ No ☐ Suspected : Please describe: _____
☐ Yes: Diagnosis By whom? Date

**Was Child referred to this program?** ☐No ☐Yes If yes, by whom? (Please check all that apply): ☐ CPS ☐Early Head Start
☐ Social Service/Health Agency ☐ Doctor/Hospital ☐ Even Start Literacy Program ☐ Other:

**Please check all that currently apply to you and your family and attach proof when applicable:**
☐ Electronic Benefit Card (EBT) Gateway Card ☐ CalWORK's ☐ Food Stamps ☐ SSI ☐ Parent Disabled
☐ Preganant ☐ W.I.C.#_____ ☐ Live within 10 Blocks from the Head Start center
☐ Homeless/Shelter ☐ Crisis (death, violence, illness, fire, parent incarcerated) ☐ Teen Parent under 19 years need HS services
☐ Enrolled in School/ESL classes/Even Start Literacy Program ☐ Employed part-time ☐ Employed full-time

**I certify** that this information is true, and if any information is false, my participation in this program may be terminated. I also understand that the information in this application will be in strict confidence, and my child's file is accessible to me during normal business hours.

**Parent/Guardian's Signature:** _____**Relationship:** _____**Date:** _____

Receiving Staff's Signature: _____Title _____Date_____