Applicant & Family Member Information

Minnesota Valley Action Council
Head Start Program 2015-2016

Adult 1 (Primary)

NAME: First	Middle	Last	Suffix	Birthday	Gender	SSN

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: ____________

Hispanic
☐ Yes
☐ No

English Proficiency
☐ None
☐ Little
☐ Moderate
☐ Proficient

Other Language

Other Language Proficiency
☐ Poor
☐ Moderate
☐ Proficient

Highest Grade Completed
☐ Associate's ☐ Grade 10
☐ Bachelor's ☐ Grade 11
☐ Col or Adv Train ☐ Grade 12
☐ GED ☐ < Grade 9
☐ HS Graduate ☐ Master's

Employment Status
☐ Full Time ☐ Full Time & Training
☐ Part Time ☐ Part Time & Training
☐ Seasonal ☐ Training or School
☐Unemployed ☐ Retired or Disabled
Date Employed ____ Date Unemployed ____

Child's Relationship
☐ Natural/Adopted/Step
☐ Grandchild
☐ Niece/Nephew
☐ Foster
☐ Other

Custody
☐ Yes
☐ No

Check all that apply:
☐ Lives with Family
☐ Provides Financial Support
☐ Teen Parent

Primary Health Coverage
☐ Blue Plus ☐ Private
☐ MA ☐ None
☐ U-Care ☐ Military Insurance (Ex: Tri-Care)
☐ SCHA ☐ Other -- Specify:

Parent Pregnant
☐ yes
☐ no

Parent Veteran
☐ yes
☐ no

Parent Disabled
☐ yes
☐ no

Email:

Adult 2 (Secondary)

NAME: First	Middle	Last	Suffix	Birthday	Gender	SSN

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: ____________

Hispanic
☐ Yes
☐ No

English Proficiency
☐ None
☐ Little
☐ Moderate
☐ Proficient

Other Language

Other Language Proficiency
☐ Poor
☐ Moderate
☐ Proficient

Highest Grade Completed
☐ Associate's ☐ Grade 10
☐ Bachelor's ☐ Grade 11
☐ Col or Adv Train ☐ Grade 12
☐ GED ☐ < Grade 9
☐ HS Graduate ☐ Master's

Employment Status
☐ Full Time ☐ Full Time & Training
☐ Part Time ☐ Part Time & Training
☐ Seasonal ☐ Training or School
☐Unemployed ☐ Retired or Disabled
Date Employed ____ Date Unemployed ____

Child's Relationship
☐ Natural/Adopted/Step
☐ Grandchild
☐ Niece/Nephew
☐ Foster
☐ Other

Custody
☐ Yes
☐ No

Check all that apply:
☐ Lives with Family
☐ Provides Financial Support
☐ Teen Parent

Primary Health Coverage
☐ Blue Plus ☐ Private
☐ MA ☐ None
☐ U-Care ☐ Military Insurance (Ex: Tri-Care)
☐ SCHA ☐ Other -- Specify:

Parent Pregnant
☐ yes
☐ no

Parent Veteran
☐ yes
☐ no

Parent Disabled
☐ yes
☐ no

Email:

☐ CHILD / ☐ Other Family Member

☐ ***I AM APPLYING FOR THIS CHILD TO BE IN HEAD START***

NAME: First	Middle	Last	Suffix	Birthday	Gender	SSN

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: ____________

Hispanic
☐ Yes
☐ No

English Proficiency
☐ None
☐ Little
☐ Moderate
☐ Proficient

Other Language

Other Language Proficiency
☐ Poor
☐ Moderate
☐ Proficient

Relationship to Head Start child
☐ Sibling ☐ Foster Sibling
☐ Grandparent ☐ Friend
☐ Aunt / Uncle ☐ None

If 19 or older, please list Highest Grade Complete: ____________

Incarcerated Parent? ☐ Yes ☐ No

Disability: ☐ Yes ☐ No
(if yes, attach documentation)

Primary Health Coverage
☐ Blue Plus ☐ SCHA
☐ MA ☐ U-Care
☐ Private ☐ None
☐ Military Insurance (Ex: Tri-Care)
☐ Other -- Specify:

Other Health Coverage
☐ Blue Plus ☐ SCHA
☐ MA ☐ U-Care
☐ Private ☐ None
☐ Military Insurance (Ex: Tri-Care)
☐ Other -- Specify:

(complete if this is the Head Start applicant)
Doctor **Dentist**

Applicant & Family Member Information continued

Head Start Program 2015-2016

☐ CHILD / ☐ Other Family Member

☐ I AM APPLYING FOR THIS CHILD TO BE IN HEAD START

NAME: First	*Middle*	*Last*	*Suffix*	*Birthday*	*Gender*	*SSN*

Race	*Hispanic*	*English Proficiency*	*Other Language*	*Other Language Proficiency*	*Relationship to Head Start child*
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: ____________	☐ Yes ☐ No	☐ None ☐ Little ☐ Moderate ☐ Proficient		☐ Poor ☐ Moderate ☐ Proficient	☐ Sibling ☐ Foster Sibling ☐ Grandparent ☐ Friend ☐ Aunt / Uncle ☐ None

If 19 or older, please list Highest Grade Complete: ____________	*Incarcerated Parent?* ☐ Yes ☐ No	*Disability:* ☐ Yes ☐ No *(if yes, attach documentation)*
Primary Health Coverage ☐ Blue Plus ☐ SCHA ☐ MA ☐ U-Care ☐ Private ☐ None ☐ Military Insurance (Ex: Tri-Care) ☐ Other -- Specify:	*Other Health Coverage* ☐ Blue Plus ☐ SCHA ☐ MA ☐ U-Care ☐ Private ☐ None ☐ Military Insurance (Ex: Tri-Care) ☐ Other -- Specify:	*(complete if this is the Head Start applicant)* *Doctor* *Dentist*

☐ CHILD / ☐ Other Family Member

☐ I AM APPLYING FOR THIS CHILD TO BE IN HEAD START

NAME: First	*Middle*	*Last*	*Suffix*	*Birthday*	*Gender*	*SSN*

Race	*Hispanic*	*English Proficiency*	*Other Language*	*Other Language Proficiency*	*Relationship to Head Start child*
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: ____________	☐ Yes ☐ No	☐ None ☐ Little ☐ Moderate ☐ Proficient		☐ Poor ☐ Moderate ☐ Proficient	☐ Sibling ☐ Foster Sibling ☐ Grandparent ☐ Friend ☐ Aunt / Uncle ☐ None

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☐ CHILD / ☐ Other Family Member

☐ I AM APPLYING FOR THIS CHILD TO BE IN HEAD START

NAME: First	*Middle*	*Last*	*Suffix*	*Birthday*	*Gender*	*SSN*

Race	*Hispanic*	*English Proficiency*	*Other Language*	*Other Language Proficiency*	*Relationship to Head Start child*
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: ____________	☐ Yes ☐ No	☐ None ☐ Little ☐ Moderate ☐ Proficient		☐ Poor ☐ Moderate ☐ Proficient	☐ Sibling ☐ Foster Sibling ☐ Grandparent ☐ Friend ☐ Aunt / Uncle ☐ None

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Applicant & Family Member Information continued

Head Start Program 2015-2016

☐ **CHILD** / ☐ **Other Family Member**

☐ ***I AM APPLYING FOR THIS CHILD TO BE IN HEAD START***

NAME: ***First*** ***Middle*** ***Last*** ***Suffix*** | ***Birthday*** | ***Gender*** | ***SSN***

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: ____________

Hispanic ☐ Yes ☐ No

English Proficiency ☐ None ☐ Little ☐ Moderate ☐ Proficient

Other Language

Other Language Proficiency ☐ Poor ☐ Moderate ☐ Proficient

Relationship to Head Start child ☐ Sibling ☐ Grandparent ☐ Aunt / Uncle ☐ Foster Sibling ☐ Friend ☐ None

If 19 or older, please list Highest Grade Complete:____________

Incarcerated Parent? ☐ Yes ☐ No

Disability: ☐ Yes ☐ No ***(if yes, attach documentation)***

Primary Health Coverage
☐ Blue Plus ☐ SCHA
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☐ Private ☐ None
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☐ Other -- Specify:

Other Health Coverage
☐ Blue Plus ☐ SCHA
☐ MA ☐ U-Care
☐ Private ☐ None
☐ Military Insurance (Ex: Tri-Care)
☐ Other -- Specify:

(complete if this is the Head Start applicant)
Doctor ***Dentist***

☐ **CHILD** / ☐ **Other Family Member**

☐ ***I AM APPLYING FOR THIS CHILD TO BE IN HEAD START***

NAME: ***First*** ***Middle*** ***Last*** ***Suffix*** | ***Birthday*** | ***Gender*** | ***SSN***

Race
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Other Language Proficiency ☐ Poor ☐ Moderate ☐ Proficient

Relationship to Head Start child ☐ Sibling ☐ Grandparent ☐ Aunt / Uncle ☐ Foster Sibling ☐ Friend ☐ None

If 19 or older, please list Highest Grade Complete:____________

Incarcerated Parent? ☐ Yes ☐ No

Disability: ☐ Yes ☐ No ***(if yes, attach documentation)***

Primary Health Coverage
☐ Blue Plus ☐ SCHA
☐ MA ☐ U-Care
☐ Private ☐ None
☐ Military Insurance (Ex: Tri-Care)
☐ Other -- Specify:

Other Health Coverage
☐ Blue Plus ☐ SCHA
☐ MA ☐ U-Care
☐ Private ☐ None
☐ Military Insurance (Ex: Tri-Care)
☐ Other -- Specify:

(complete if this is the Head Start applicant)
Doctor ***Dentist***

☐ **CHILD** / ☐ **Other Family Member**

☐ ***I AM APPLYING FOR THIS CHILD TO BE IN HEAD START***

NAME: ***First*** ***Middle*** ***Last*** ***Suffix*** | ***Birthday*** | ***Gender*** | ***SSN***

Race
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Other Language Proficiency ☐ Poor ☐ Moderate ☐ Proficient

Relationship to Head Start child ☐ Sibling ☐ Grandparent ☐ Aunt / Uncle ☐ Foster Sibling ☐ Friend ☐ None

If 19 or older, please list Highest Grade Complete:____________

Incarcerated Parent? ☐ Yes ☐ No

Disability: ☐ Yes ☐ No ***(if yes, attach documentation)***

Primary Health Coverage
☐ Blue Plus ☐ SCHA
☐ MA ☐ U-Care
☐ Private ☐ None
☐ Military Insurance (Ex: Tri-Care)
☐ Other -- Specify:

Other Health Coverage
☐ Blue Plus ☐ SCHA
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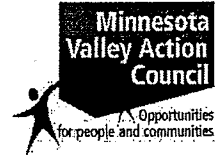
☐ Private ☐ None
☐ Military Insurance (Ex: Tri-Care)
☐ Other -- Specify:

(complete if this is the Head Start applicant)
Doctor ***Dentist***

Minnesota Valley Action Council
2015-2016 Head Start Program



Family Information & Emergency Contacts

Applicant Name: ______________________________ Birthday ____________

Family Information

Living Address	*Zip*	*City*	*State*	*County*
Mailing Address (if different)	*Zip*	*City*	*State*	*County*

Phone Numbers	*Type (check one)*	*Note (for example, an extension or best time to call)*
	☐ Cell ☐ Home ☐ Work ☐ Other	
	☐ Cell ☐ Home ☐ Work ☐ Other	
	☐ Cell ☐ Home ☐ Work ☐ Other	

Parental Status (check one)	*Primary Language at Home*	*Homeless Family*	*Military Family*	*Referred by Child Welfare Agency*	*Receiving SNAP*	*WIC*
☐ One ☐ Two		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Emergency Contacts

Contact 1

Name	*Relationship*	*Emergency Contact* ☐ Yes ☐ No	*Release To* ☐ Yes ☐ No
Address	*Zip*	*City*	*State*
Primary Language	If English in not the primary language, is an interpreter needed? ☐ yes ☐ no		
Phone # 1 ☐ Cell ☐ Home ☐ Work	Phone # 2 ☐ Cell ☐ Home ☐ Work	Phone # 3 ☐ Cell ☐ Home ☐ Work	

Contact 2

Name	*Relationship*	*Emergency Contact* ☐ Yes ☐ No	*Release To* ☐ Yes ☐ No
Address	*Zip*	*City*	*State*
Primary Language	If English in not the primary language, is an interpreter needed? ☐ yes ☐ no		
Phone # 1 ☐ Cell ☐ Home ☐ Work	*Phone # 2* ☐ Cell ☐ Home ☐ Work	*Phone # 3* ☐ Cell ☐ Home ☐ Work	

Contact 3

Name	*Relationship*	*Emergency Contact* ☐ Yes ☐ No	*Release To* ☐ Yes ☐ No
Address	*Zip*	*City*	*State*
Primary Language	If English in not the primary language, is an interpreter needed? ☐ yes ☐ no		
Phone # 1 ☐ Cell ☐ Home ☐ Work	*Phone # 2* ☐ Cell ☐ Home ☐ Work	*Phone # 3* ☐ Cell ☐ Home ☐ Work	

Rev Jan 2015

Applicant Name: ______________________________

Applicant DOB: ______________________________

Head of Household: ___________________________

Minnesota Valley Action Council
Head Start Program
Agency Specific Fields
2015-2016

Agency Specific Fields

Able to Transport	*Transport from*	*Need daycare in order to find or maintain employment before enrollment?*	*Family Receives County daycare assistance?*	*Child is attending another program?*
☐ yes ☐ no	☐ home ☐ daycare	☐ yes ☐ no	☐ yes ☐ no	☐ Migrant Head Start ☐ ECSE M T W R F ☐ Other: ________ AM PM

	Need all day care	*All day care reason*
Daycare Name:	☐ yes ☐ no (if yes, please select reason: next question) ➔	☐ Work ☐ School ☐ Work and School ☐ Other: ________
Daycare Address & City:		
Daycare Phone:		

Daycare Type (select one):

☐ Adult non-relative (child's home)
☐ Adult non-relative (non-relative's home)
☐ Child Care Center
☐ Not Arranged yet
☐ Older Sibling (12 or older)
☐ Older Sibling (Under age 12)
☐ Relative in child's home
☐ Relative in relative's home
☐ Other: ______________________________

Type of Housing

☐ House (Duplex / Townhome)
☐ Apartment
☐ Mobile home / Trailer
☐ *Community shelter
☐ *Homeless / No housing
☐ *Hotel / Motel room
☐ Migrant housing

*if family selects an answer with an * the verification of living situation form need to be completed

Housing Payment Arrangement (select one)

☐ Own housing
☐ Rent housing
☐ Exchange services for housing
☐ Make no payment for housing
☐ Receive subsidized housing
☐ Other: Specify ____________________

*if family does not own/rent or choose to share housing, the verification of living situation form needs to be completed.

Length of time at Current Address

☐ Less than 6 months ➔
☐ 6-11 months ➔
☐ 1-2 years
☐ More than 2 years

Number of times family has moved in the **past 11 months:** ______

Family type (select one)

☐ Two parent family
☐ Single parent family (mother only)
☐ Single parent family (father only)
☐ Single parent (mother only) living with partner
☐ Single parent family (father only) living with partner
☐ Other relative(s)
☐ Foster family
☐ Other family type

Marital Status

☐ Married
☐ Single
☐ Widowed
☐ Divorced
☐ Separated

Parent or Guardian Signature: X ______________________________ Date: ____/____/____

My signature certifies that the documents and information I have provided concerning eligibility are accurate to the best of my knowledge. If it is determined that any eligibility information has been deliberately falsified, this application will be null and void. I understand a completed application does not guarantee a place for my child in a program. Applications are reviewed at the Head Start Administrative Office. Parents are notified if their child has been selected