

**CADC HEAD START/ABC APPLICATION**

Date interviewed: \_\_\_\_\_ Center: \_\_\_\_\_

Enrollment Date: \_\_\_\_\_ Transferred In: \_\_\_\_\_ Transferred from: \_\_\_\_\_  
(Check) (CADC center name)

Dropped Date: \_\_\_\_\_ Transferred Out: \_\_\_\_\_ Transferred to: \_\_\_\_\_  
(Check) (CADC center name or Non-agency)

Re-enrollment Date: \_\_\_\_\_

**STUDENT DATA INFORMATION:**

Student Number \_\_\_\_\_ Family Number \_\_\_\_\_ Income \_\_\_\_\_

First Year Student \_\_\_\_\_ Second Year Student \_\_\_\_\_ Number in Family \_\_\_\_\_

Below Poverty Guidelines \_\_\_\_\_ Above Poverty Guidelines \_\_\_\_\_ Meal Category \_\_\_\_\_

**CHILD INFORMATION:**

Child's legal name: \_\_\_\_\_  
last first middle

DOB: \_\_\_\_\_ Age of child: \_\_\_\_\_ (at enrollment)  
mo / day / yr (Must be 3 by August 1, 2010)

SSN: \_\_\_\_\_ Medicaid \_\_\_\_\_ Private Insurance \_\_\_\_\_ Non Insured \_\_\_\_\_

Address: \_\_\_\_\_  
street city state zip

Home phone: \_\_\_\_\_ Message phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Gender: \_\_\_\_\_ Race: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
F or M

**LEGAL RESPONSIBILITY OF CHILD:**

Mother \_\_\_\_\_ Father \_\_\_\_\_ Both parents \_\_\_\_\_ Other adult \_\_\_\_\_

If other adult, name relationship \_\_\_\_\_

Parent's marital status: Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widow \_\_\_\_\_

**HOUSEHOLD INFORMATION:**

**MOTHER:**

Legal name: \_\_\_\_\_  
last first middle

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
mo / day / yr

Employed: Yes \_\_\_\_\_ No \_\_\_\_\_ In school: Yes \_\_\_\_\_ No \_\_\_\_\_

Work hours \_\_\_\_\_ to \_\_\_\_\_ School hours \_\_\_\_\_ to \_\_\_\_\_

Employer: \_\_\_\_\_ School: \_\_\_\_\_

Business phone: \_\_\_\_\_ School phone: \_\_\_\_\_

Home phone: \_\_\_\_\_ (if different from application). Cell phone: \_\_\_\_\_

Home address: \_\_\_\_\_ (if different from application).

Race: \_\_\_\_\_ Primary Language: \_\_\_\_\_ Education Level: \_\_\_\_\_

**FATHER:**

Legal name: \_\_\_\_\_

last

first

middle

DOB: \_\_\_\_\_

SSN: \_\_\_\_\_

mo / day / yr

Employed: Yes \_\_\_\_\_ No \_\_\_\_\_

In school: Yes \_\_\_\_\_ No \_\_\_\_\_

Work hours \_\_\_\_\_ to \_\_\_\_\_

School hours \_\_\_\_\_ to \_\_\_\_\_

Employer: \_\_\_\_\_

School: \_\_\_\_\_

Business phone: \_\_\_\_\_

School phone: \_\_\_\_\_

Home phone: \_\_\_\_\_ (if different from application). Cell phone: \_\_\_\_\_

Home address: \_\_\_\_\_ (if different from application).

Race: \_\_\_\_\_ Primary Language: \_\_\_\_\_ Education Level: \_\_\_\_\_

**MEDICAL INFORMATION:**

Family physician: \_\_\_\_\_  
Phone Number \_\_\_\_\_

Address: \_\_\_\_\_  
street city state zip

Family dentist: \_\_\_\_\_  
Phone Number \_\_\_\_\_

Address: \_\_\_\_\_  
street city state zip

In case of emergency: \_\_\_\_\_  
Phone Number \_\_\_\_\_

Address: \_\_\_\_\_  
street city state zip

Does child have any special needs?  
What? \_\_\_\_\_

Is child currently homeless, living in a shelter or halfway house?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

Has Child been diagnosed by a Professional?  
Whom? \_\_\_\_\_

Are three or more children under age 5 living in household?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

Does you child have an I.E.P./I.F.S. P.  
\_\_\_\_\_ Yes \_\_\_\_\_ No

Is child receiving services from another agency?  
Whom? \_\_\_\_\_

Do you have another child(ren) applying for or enrolled  
in Head Start.

If yes, what is the child(ren)s name(s)?  
\_\_\_\_\_

How did you hear about Head Start  
\_\_\_\_\_

**VERIFICATION OF AGE ELIGIBILITY WAS MADE BY EXAMINING THE FOLLOWING:**

Birth certificate no: \_\_\_\_\_

Copy birth certificate: Yes \_\_\_\_\_ No \_\_\_\_\_

Hospital record \_\_\_\_\_

Verified by: \_\_\_\_\_  
Name of staff Date

Health/Disabilities Concerns \_\_\_\_\_ Classroom Teacher Assigned \_\_\_\_\_