

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 September 15th, 2008)

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

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 _____

CADC HEAD START/ABC INCOME VERIFICATION

Child's Name

Parent/ Guardian's Name

Gross annual family income (person(s) legally responsible for the child except when children are wards of the state)

1. Taxable earned income (which includes money, wages, and salaries before deductions, net receipts from non-farm self-employment and farm self-employment). Income information should be available from one or more of the following sources:

A. Previous calendar year federal income tax form (or w-2 form) _____

B. A written statement from an employer(s) verifying money, wages or salary earned from the previous 12 months income. _____

C. Payroll stub(s) (military & non-military) _____

2. Additional non-taxable income that is to be counted: _____

Regular payments from the following:

3. Social security income _____

4. Unemployment compensation _____

5. Public assistance (Including AFDC, Supplemental security income, emergency assistance money payments, & non-federally funded general assistance money payments) _____

6. Child support _____

TOTAL FAMILY INCOME (TOTAL OF NUMBERS 1-6 ABOVE) _____

TOTAL NUMBER IN FAMILY _____

I have examined and verify the above information.

Staff signature _____

Date _____