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| **ELIGIBILITY DETERMINATION**  **WAITLIST APPLICATION** |

🞏CSPP/RHS (FD) 🞏CSPP/RHS (ED) 🞏CAPP 🞏CCTR/EHS/RHS 🞏FCCHEN/EHS 🞏 FCCHEN

Full-Day State Preschool Extended-Day State Preschool Alternative Center-Based General Child Care General Child Care blended General Child Care

blended with Regional Head Start layered with Regional Head Start Payment Program blended with Early Head Start with Early Head Start

Enrollment Date:

Removal Date:

Reason for Removal:

🞏 Sibling 🞏 Transfer (Attach back-up)

🔾 Sibling Name 🔾 Inner Agency

🔾 Sibling Program 🔾 Outside Agency

🞏 Walk-in 🞏 Additional Need for Services

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| PART I Parent A:  Last First    Parent B: 🞏 Present 🞏 Not Present  Last First  Family Type (mark one): 🞏 Standard/Natural 🞏 Guardianship 🞏 Foster  Street Address: Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mailing Address: Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (IF DIFFERENT FROM ABOVE)    How did you learn about our agency: 🞏 Previously enrolled 🞏 Relative 🞏 Friend 🞏 Flyer 🞏 Voice Broadcast 🞏 Newspaper 🞏 Other |
| PART IIHow many children do you have that need child care?  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Names of Children** | **DOB** | **Infant** | **Toddler** | **Preschool** | **Special Needs** | **Limited English** | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |
| PART III Total number of family members: Adults \_\_\_\_\_\_\_\_\_\_ Children \_\_\_\_\_\_\_\_\_\_  *Note: Family size; not household size* |
| PART IV Head Start Annual Income $ State Monthly Income $ |

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| PART V Source of Income: (Check those that apply)   * Wages 🞏 Unemployment Benefits 🞏 Foster Payment * Cash Aid 🞏 Child Support 🞏 Other * Social Security 🞏 SSI/Disability | |
| PART VI Reason for Needing Service: (M-Mother/F-Father/G-Guardian)  CPS/At Risk Homeless Other  Employed Parental Incapacity  Seeking Employment Vocational Training  Seeking Housing \_\_\_\_\_\_ ESL/GED Program | |
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| CONTACT DATES AND COMMENTS | STAFF INITIALS |
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| **Part VIII**   * Eligible * How to Apply Session Date: Time: * Mailed Map / Appointment Confirmation * Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Preferred Site: * Language (circle): English Spanish Other * Not Eligible * Transferred to StanWait and/or Referred to Extended-Day Head Start (no need) | |
| Print Agency Representative Name Application Date | |