South Jamaica Center for Children and Parents, Inc.
Head Start Eligibility Application

Application Completed -- In-Person ____ Telephone ____ Eligibility Date:_____

Applicant	Check box for Prenatal Mom ☐

First Name: _____ **Middle Name:** _____ **Last Name:** _____

Date of Birth: _____/_____/_____ ☐ Age Eligibility Verified **Source of Verification:**_____

Gender: ☐ Male ☐ Female **Primary Language** _____ **Other Language:** _____

Ethnicity: Hispanic or Latino ☐ Yes ☐No

Race: ☐American Indian/Alaska Native ☐Asian ☐Bi-racial/Multi-racial ☐ Black/African American ☐Caucasian / White ☐Native Hawaiian / Pacific Islander

☐Other, specify_____ ☐Unspecified, explain_____

Medical Insurance: ☐Yes ☐No **Provider:** _____ **Group #:**_____ **Policy#:**_____

Doctor: _____ **Phone:**_____ **Dentist:**_____ **Phone:**_____

Preferred Hospital_____ **Clinic**_____

Adult 1

First Name: _____ **M. Initial:** _____ **Last Name:** _____

Date of Birth: _____/_____/_____ **Gender:** ☐Male ☐Female

Primary Language: _____ **Other Language:** _____ **Ethnicity:** Hispanic or Latino ☐ Yes ☐ No

Race: ☐American Indian or Alaska Native ☐Asian ☐Bi-racial/Multi-racial ☐ Black / African American ☐Caucasian / White ☐Native Hawaiian/Pacific Islander
☐Other, specify_____ ☐Unspecified, explain_____

Education Level: ☐Bachelor or Advanced Degree ☐College Degree or Training School Certificate ☐Some College/ Vocational/ Associate Degree
☐High School Graduate ☐GED ☐Grade 12 ☐Grade 11 ☐Grade 10 ☐Grade 9 or Less ☐Unknown

Employment Status: ☐ Full-Time ☐Full-Time & Training ☐ Part-time ☐Part-Time & Training ☐Job Training or School
☐ Seasonal ☐ Migrant Farm Worker ☐Retired ☐Self Employed ☐Unemployed ☐Disabled

Child's Relationship: ☐Natural/Adopted/Step ☐Grandchild ☐Relative ☐Foster ☐Other _____ **Custody:** ☐Yes ☐No

Check all that apply: ☐Lives with Family ☐Provides Financial Support ☐Teen Parent (Does teen parent receive subsidy? ☐Yes ☐No)

E-mail Address:_____ Comments:_____

Adult 2

First Name: _____ **M. Initial:** _____ **Last Name:** _____

Date of Birth: _____/_____/_____ **Gender:** ☐Male ☐Female

Primary Language: _____ **Other Language:** _____ **Ethnicity:** Hispanic or Latino ☐Yes ☐ No

Race: ☐American Indian or Alaska Native ☐Asian ☐Bi-racial/Multi-racial ☐ Black / African American ☐Caucasian / White ☐Native Hawaiian/Pacific Islander
☐Other, specify_____ ☐Unspecified, explain_____

Education Level: ☐Bachelor or Advanced Degree ☐College Degree or Training School Certificate ☐Some College/ Vocational/ Associate Degree
☐High School Graduate ☐GED ☐Grade 12 ☐Grade 11 ☐Grade 10 ☐Grade 9 or Less ☐Unknown

Employment Status: ☐ Full-Time ☐Full-Time & Training ☐ Part-time ☐Part-Time & Training ☐Job Training or School
☐ Seasonal ☐ Migrant Farm Worker ☐Retired or Disabled ☐Self Employed ☐Unemployed

Child's Relationship: ☐Natural/Adopted/Step ☐Grandchild ☐Relative ☐Foster ☐Other _____ **Custody:** ☐Yes ☐No

Check all that apply: ☐Lives with Family ☐Provides Financial Support ☐Teen Parent (Does teen parent receive subsidy? ☐Yes ☐No)

E-mail Address:_____ Comments:_____

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Applicant's Name:	Date of Birth:	Eligibility Date:

Additional Adults/Children (Non-Applicants) *A member of the Family Unit & Supported by the Income of the Parent/Guardian of the HS Applicant*

First Name	MI	Last	Date of Birth	Gender

Family Information

Living Address_____City_____, New York   Zip_____

Mailing Address_____ City_____, New York   Zip_____

Phone Numbers: Cell_____   Home_____   Work_____   Other_____

Cell_____   Home_____   Work_____   Other_____

Parental Status	Active Duty Military	Referred by Child Welfare Agency	Receive Snap	Receive WIC
☐One ☐Two	☐ Yes ☐No	☐ Yes ☐No	☐ Yes ☐No	☐ Yes ☐No

Homeless Family:
Is the living address a fixed, regular, and adequate night time residence?   ☐ Yes   ☐ No (Indicates Homeless)

Emergency Contacts

First	Last	Relation to Child	Telephone	Check One or Both
			Home:	☐ Release To ☐ Emergency Contact
			Cell:	
			Work:	
			Home:	☐ Release To ☐ Emergency Contact
			Cell:	
			Work:	
			Home:	☐ Release To ☐ Emergency Contact
			Cell:	
			Work:	

Restricted from Picking-up:

Court Order

First_____ Last_____ Relation to Child_____ Reason_____ ☐

First_____ Last_____ Relation to Child_____ Reason_____ ☐

CHILD TRANSPORTATION

Does this child receive transportation? ☐ Yes ☐ No *(Complete directions to home from school for yes or no answer)*

Pick up Location: _____ **Drop off Location:** _____
Directions:
_____

_____

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Date of Birth:_____   **Eligibility Date:**

FAMILY INCOME

AIC – *Annual Income Calculator*: **Annually**: No conversion needed   **Monthly**: Multiply by 12   **Semi Monthly:** Multiply by 24
Bi Weekly: Multiply by 26   **Weekly**: Multiply by 52

Income Source	Calculate all income with the exact amount reported on any income source.			Check all documentation used to verify income:
1. Employment	**Amount**	**X AIC**	**= Annual Income**	☐ Income Tax Form 1040
PRIMARY CAREGIVER				
☐ Full Time *(Use Gross Income)*				☐ W-2
☐ Part Time *(Use Gross Income)*				
☐ Self-Employment *(Use Net Income)*				☐ TANF Documentation
SECONDARY CAREGIVER				☐ Pay Stub Pay Envelopes
☐ Full Time *(Use Gross Income)*				
☐ Part Time *(Use Gross Income)*				☐ Unemployment
☐ Self-Employment *(Use Net Income)*				
☐ **Income Tax Return Statement / W-2**				☐ Child Support
Section 1: Total Annual Income:				
	Amount	**X AIC**	**= Annual Income**	☐ Written Statements From Employers
2. Child Support				
Section 2: Total Annual Income:				☐ Foster Care Documentation
3. Public Assistance *(Categorically Eligible)*	**Amount**	**X AIC**	**= Annual Income**	
☐ TANF *(Temporary Assistance to Needy Families)*				☐ Kinship Care Documentation
☐ SSI (Supplemental Security Income)				
☐ Emergency Assistance Money Payment				☐ SSI Documentation
Section 3: Total Annual Income:				
4. Foster Care/ Kinship Care *(Categorically Eligible)*	**Amount**	**X AIC**	**= Annual Income**	☐ Self Employed
☐ Foster Care				
☐ Kinship Care				☐ Support Letter
Section 4: Total Annual Income:				
5. Other Income	**Amount**	**X AIC**	**= Annual Income**	☐ Self-Declaration of Income
☐ Social Security for the Aged/Disabled/Survivors				
☐ Unemployment/Workers' Compensation/Strike Benefits				☐ Other
☐ Pension: Employee, Private and/or Military				
☐ Insurance or Annuity Payments				If *other*, please explain:
☐ College/ University Scholarships/Grants/Fellowships/etc				
☐ Other Income *(Please Specify)*				_____
Section 5: Total Annual Income:				
Total Number in Family Unit:	**GRAND TOTAL ANNUAL INCOME:**			

☐ **No Income**

How long has this family had no income? _____

Who provides food and shelter? _____

Homeless: Is the living address a fixed, regular, and adequate night time residence?   ☐ Yes   ☐ No (Indicates Homeless)

In accordance with Head Start regulations, I certify that I have in person examined the source(s) of documentation as indicated above. I have calculated all income for the previous year or the preceding 12 months, as well as viewed the birth verification for the child applicant, and found the child to be:

Income Category *(Check One)*   **Age Category** *(Check One)*
☐ Below 100% of Poverty   ☐ Age Eligible for Head Start
  ☐ Between 100% - 130% of Poverty   ☐ Not Age Eligible for HS (Date of Eligibility_____)
☐ Over 130% of Poverty

Staff Signature_____ **Date**_____

Staff Printed Name_____ **Title**_____

Supervisor's Signature _____ ***Date*** _____

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Applicant's Name:	Date of Birth:	Eligibility Date:

Eligibility Criteria

Check all that Apply:

☐ Referral from Administration for Children's Services (ACS)
☐ Disability Status *(Certified IEP)*
☐ Foster Parent
☐ Legal Guardian *(other than biological parent)*
☐ Cash Assistance and Transitional Child Care
☐ Homeless
☐ Non-English Speaking / Dual Language Learner or English as Second Language
☐ Teen parent attending school in local school district
☐ Teen parent attending a GED Program, Vocational School or College
☐ Teen parent not currently attending school
☐ Special Needs _____
☐ By checking this box the parent /guardian indicates that one or more of the following situations occurred in the last 12 month
Child Protection Services is working with Family
Physical or mental health problems, disabled or terminal illness
Death in the immediate family in last year
High risk pregnancy
Alcohol & Substance Abuse
Dislocated or Seasonal Worker
Military deployed
Domestic Violence
Incarcerated Parent
☐ Single Parent
☐ Parent / Guardian is enrolled in CLIP program at York College
☐ Parent/Guardian is enrolled in ESL, GED program at York College
☐ Parent/Guardian is enrolled at York College
☐ Parent/Guardian is enrolled in GED, Vocational Training or College
☐ Parent/Guardian is enrolled for 12+ semester hours
☐ Parent/Guardian completed 20+ semester hours
☐ Parent/Guardian works 25+ hours per week with no caregiver in home
☐ Parent/Guardian works 15 - 24 hours per week with no caregiver in home
☐ Parent/Guardian works less than 15 hours per week with no caregiver in home

Program Information

Program Model: ☐ Head Start   ☐ Full-year needed

Program Site_____

Comments_____

I certify that the information given on all four pages of this application is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent/Guardian Signature_____ **Application Completion Date**_____

Verifying Staff Member Signature_____ **Date**_____

Supervisor's Signature _____ ***Selection Criteria Score***_____ ***Date***_____