STEP, INC. HEAD START/EARLY HEAD START

Program Year: ____/____
Interview Date: ___/___/___
Enrollment Date: ___/___/___
ChildPlus Date: ___/___/___
CP/APP #: ___________
Termination Date: ___/___/___

APPLICANT INFORMATION

Use Blue or Black Ink ONLY

☐Head Start	☐Early Head Start - Child	☐ Early Head Start – Pregnant Mom Due: Date ___/___/___

Child's Name (First, Middle, Last, Suffix)	Nickname	DOB	Gender	SSN
			☐ Male ☐ Female	

Race
- ☐ Asian
- ☐ Black
- ☐ White
- ☐ American Indian/Alaskan Native
- ☐ Hawaiian/Pacific Islander
- ☐ Multi-Racial
- ☐ Other ____________________

Hispanic
- ☐ Yes
- ☐ No

Any Other Language?

English Proficiency
- ☐ None
- ☐ Little
- ☐ Moderate
- ☐ Proficient

Other Language Proficiency
- ☐ Poor
- ☐ Moderate
- ☐ Proficient

Primary Health Coverage
- ☐ Medicaid
- ☐ Private Insurance
- ☐ No Health Insurance
- ☐ Other

Medicaid Eligibility
- ☐ Not Eligible
- ☐ On Medicaid
- ☐ Potentially

Medicaid Number: ________________________________

Private Insurance Name: ________________________________
Policy ID:
Group Number: ______________________
Member ID: _________________________

911 Address

____
House Number and Street /PO Box **City, VA** **Zip Code**

Mailing Address

____
House Number and Street /PO Box **City, VA** **Zip Code**

Parent/Guardian Name: ________________________________
☐ Cell ☐ Home ☐ Work ☐ Other
Phone Number: ______________________________________
Email: ____

Parent/Guardian Name: ________________________________
☐ Cell ☐ Home ☐ Work ☐ Other
Phone Number: ______________________________________
Email: ____

Current Day Care Provider:
Name: _______________________________________ Address: ____
Previous Day Care Provider:
Name: _______________________________________ Address: ____
Is child also enrolled in another program/school?
☐ Yes, Name of Program: ____
☐ No

Info: (check all that apply) ☐Food Stamps ☐ Access to Auto ☐TANF Recipient ☐ Homebound
Senatorial District: ☐ Franklin County: or ☐ Patrick County: 15 19 20 ☐ Other
House District: ☐Franklin County: or ☐ Patrick County: 9 14 16 ☐ Other
Home Heating Source: ☐ Electric ☐ Fuel/oil ☐ Kerosene ☐ LPG/propane ☐ Natural gas ☐ Solar energy ☐ Wood
Ever Experienced a Housing Crisis? ☐ Yes ☐ No **Benefit from Financial Counseling?** ☐ Yes ☐ No **Benefit from Parental Counseling?** ☐ Yes ☐ No
Where did you hear about us? ____
Would you like to be referred or receive information about other STEP programs? ☐ YES ☐ NO

Child's Name ________________________________ DOB __________________ Enrollment Date __________________

#1 PARENT/GUARDIAN (HEAD OF HOUSEHOLD) INFORMATION - Custody: □Yes □ No Custody Order/Agreement: □Yes □No

Relationship to Child: □Biological/Adopted/Stepchild □ Foster □ Grandchild □ Other Relative □Other

Check all that apply: □Lives with family □Provides financial support **Family Type:** □Single Male □ Single Female □2 Parent HH

Name (First, Middle, Last, Suffix)	DOB	Gender	SSN
		☐ Male ☐ Female	

Race	Hispanic	Other Language	Health Insurance
□ Asian □ Black □ White □ American Indian/Alaskan Native □ Hawaiian/Pacific Islander □ Multi-Racial □ Other ____________________	☐ Yes ☐ No **English Proficiency** ☐ None ☐ Little ☐ Moderate ☐Proficient	**Proficiency** ☐ Poor ☐ Moderate ☐ Proficient	☐ Medicaid ☐ Private Insurance ☐ No Insurance ☐ Other

Highest Grade Completed	Employment Status	Employer's Name
□ Master's □ Associate's □ Bachelor's □ College Degree/Training □ College or Advance Training □ GED □ HS Graduate □ Grade 12 □ Grade 11 □ Grade 10 □ <Grade 9	☐ Full Time ☐ Part Time ☐ Seasonal ☐ Full Time and Training ☐ Part Time &Training ☐ Training or School ☐ Retired or Disabled ☐ Unemployed	____________________ **Employer's Address** ____________________ **Employer's Phone Number** ____________________

Primary Language at Home	Homeless Family	WIC	SSI
____________________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Referred by Child Welfare Agency	**Veteran**	**Receiving Snap**	**TANF**
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

#2 ADULT LIVING IN HOUSEHOLD - Custody Order/Agreement: □Yes □No

Relationship to Child: □Biological/Adopted/Stepchild □ Foster □ Grandchild □ Other Relative □Other

Check all that apply: □Lives with family □Provides financial support

Name (First, Middle, Last, Suffix)	DOB	Gender	SSN
		☐ Male ☐ Female	

Race	Hispanic	Other Language	Veteran	Health Insurance
☐ Asian ☐ Black ☐ White ☐ Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Multi-Racial	☐ Yes ☐ No **English Proficiency** ☐ None ☐ Little ☐ Moderate☐ Proficient	**Proficiency** ☐ Poor ☐ Moderate ☐ Proficient	☐ Yes ☐ No	☐ Medicaid ☐ Private Insurance ☐ No Insurance ☐ Other

Highest Grade Completed	Employment Status	Employer's Name
☐ Master's ☐ Grade 11 ☐ Associate's ☐ Grade 10 ☐ Bachelor's ☐ <Grade 9 ☐ College Degree/Training ☐ College or Advance Training ☐ GED ☐ HS Graduate ☐ Grade 12	☐ Full Time ☐ Part Time ☐ Seasonal ☐ Full Time & Training ☐ Part Time & Training ☐ Training or School ☐ Retired or Disabled ☐ Unemployed	____________________ **Employer's Address** ____________________ **Employer's Phone Number** ____________________

Child's Name ______________________ DOB ______________ Enrollment Date ______________

ADDITIONAL CHILD ☐ **Check if NO ADDITIONAL CHILDREN**

Name (First, Middle, Last, Suffix)	**DOB**	**Gender** ☐ Male ☐ Female	**SSN**

Race ☐ Asian ☐ American Indian/Alaskan 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

Primary Health Coverage ☐ Medicaid ☐ No Health Insurance ☐ Private Insurance ☐ Other	**Other Coverage:** ______________	**Currently In Child Care** ☐Yes ☐No Name of Current Provider: ______________________ Name of Previous Provider: ______________________

ADDITIONAL CHILD ☐ **Check if NO ADDITIONAL CHILDREN**

Name (First, Middle, Last, Suffix)	**DOB**	**Gender** ☐ Male ☐ Female	**SSN**

Race ☐ Asian ☐ American Indian/Alaskan 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

Primary Health Coverage ☐ Medicaid ☐ No Health Insurance ☐ Private Insurance ☐ Other	**Other Coverage:** ______________	**Currently In Child Care** ☐Yes ☐No Name of Current Provider: ______________________ Name of Previous Provider: ______________________

ADDITIONAL CHILD ☐ **Check if NO ADDITIONAL CHILDREN**

Name (First, Middle, Last, Suffix)	**DOB**	**Gender** ☐ Male ☐ Female	**SSN**

Race ☐ Asian ☐ American Indian/Alaskan 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

Primary Health Coverage ☐ Medicaid ☐ No Health Insurance ☐ Private Insurance ☐ Other	**Other Coverage:** ______________	**Currently In Child Care** ☐Yes ☐No Name of Current Provider: ______________________ Name of Previous Provider: ______________________

Child's Name ______________________________ DOB _________________ Enrollment Date _________________

STEP, INC. HEAD START PROGRAM INTAKE FORM
FAMILY CONCERNS – PLEASE CHECK ALL THAT APPLY.

(*This information is confidential and will be used only in the application screening process.*)

☐ A1 - Foster Care ☐ A1 - Homeless	☐ A2-Returning HS or EHS	☐ B1 - Verified Disability of Child • Speech, developmental, etc. • (need documentation)
☐ B2 - Drug Dependent Child	☐ B3 - History of Domestic Violence	☐ B4 - Substance Abuse
☐ B5 - Mental Health Concerns of Individual or Family	☐ B6 – Recent Separation/Divorce *(within the last 2 years)*	☐ B7 - Lack of Health Care Coverage (Insurance)
☐ B8 - Postpartum Depression	☐ B9 - Loss of Employment	☐ B10 - Lack of Affordable Housing
☐ B11 - Chronic Illness *(Individual or Family)*	☐ B12 - Teen Parent	☐ B13 - At Risk Pregnancy *(pregnant mom only)*
☐ B14 - First Pregnancy	☐ B15 - Lack GED or High School D.	☐ B16 – Single Parent/Grandparent/Family Member as Guardian
☐ B17 - Military Service (any)	☐ B18 - Recent Death of Immediate Family or Household Member	☐ B19 - Sibling Currently Enrolled in EHS or HS
☐B20 - Parent Concerns about Child Applicant (Example: medical, attention span, potty training, biting, tantrums, crying, colic, failure to thrive, low birth weight.) ***Please explain:***		
☐ B21 - In Job Training or College	☐ B22- Lack of Reliable Transportation	☐ B23 - English as a Second Language
☐ B24 - More than 2 Children Under the Age of 5	☐ B25 - Lack of Affordable Childcare	☐ B26 - Physical/Social Isolation
☐ B27 - Incarcerated Immediate Family Member	☐ B28 - Overwhelmed by Child Rearing	

READ AND SIGN BELOW

It is a federal offense to submit false information on this report and will result in immediate dismissal of this child from the STEP Head Start/Early Head Start Program. Your signature indicates that you have completed this application to the best of your ability and provided STEP Head Start/Early Head Start with accurate information.

PARENT SIGNATURE: **DATE:**

Do Not Write Below This Line! Office Use Only!

# of Family Members:	Income Guidelines 100% $ __________________ 130% $__________________	Verified Annual Income $______________________	☐ Income Eligible ☐ 100% ☐ 100-130% ☐ Over Income

☐ Income verification included	☐ Birth verification included	☐ USDA Forms included

Early Head Start	Head Start
☐ Infant ☐ Toddler ☐ Pregnant Woman	☐ Transitioning EHS 3 year old ☐ 3 year old ☐4 year old ☐ 5 year old (documentation required)

Date of Application:	**Screening Score:**		**Enrollment Date:**
Date of Interview:	**Program/County:**	**Program Year:**	**Classroom Assignment:**
Date of Screening:	**Pregnant Mom ED:**		**Termination Date:**