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 ◻ Male ◻ Female	SSN

Race	Hispanic	Any Other Language?
◻ Asian ◻ Black ◻ White ◻ American Indian/Alaskan Native ◻ Hawaiian/Pacific Islander ◻ Multi-Racial ◻ Other ________________	☐ Yes ☐ No **English Proficiency** ☐ None ☐ Little ☐ Moderate ☐ Proficient	**Other Language Proficiency** ☐ Poor ☐ Moderate ☐ Proficient

Primary Health Coverage	Medicaid Eligibility	Medicaid Number:	Private Insurance Name:
☐ Medicaid ☐ Private Insurance ☐ No Health Insurance ☐ Other	☐ Not Eligible ☐ On Medicaid ☐ Potentially	___________________________	____________________________ **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: ☐ **Does Not Apply**
Name: ____ Address: ____
Previous Day Care Provider:
Name: ____ Address: ____
Is this child also enrolled in another childcare/school? ◻ Yes ◻ No
If yes, name of childcare/school: ____

Info: (check all that apply) ◻Food Stamps ◻ Access to Auto ◻TANF Recipient ◻ Homebound
Senatorial District: ◻ Franklin County: or ◻ Patrick County: (circle) 15 19 20 ◻ Other
House District: ◻Franklin County: or ◻ Patrick County: (circle) 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** ☐ Male ☐ Female	**SSN**
Race □ Asian □ Black □ White □ American Indian/Alaskan Native □ Hawaiian/Pacific Islander □ Multi-Racial □ Other _______________	**Hispanic** ☐ Yes ☐ No **English Proficiency** ☐ None ☐ Little ☐ Moderate ☐Proficient	**Other Language** **Proficiency** ☐ Poor ☐ Moderate ☐ Proficient	**Health Insurance** ☐ Medicaid ☐ Private Insurance ☐ No Insurance ☐ Other
Highest Grade Completed □ Master's □ Associate's □ Bachelor's □ College Degree/Training □ College or Advance Training □ GED □ HS Graduate □ Grade 12 □ Grade 11 □ Grade 10 □ <Grade 9	**Employment Status** ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Full Time and Training ☐ Part Time &Training ☐ Training or School ☐ Retired or Disabled ☐ Unemployed	**Employer's Name** ______________________ **Employer's Address** ______________________ **Employer's Phone Number** ______________________	
Primary Language at Home:	**Homeless Family** ☐ Yes ☐ No	**WIC** ☐ Yes ☐ No	**SSI** ☐ Yes ☐ No
Referred by Child Welfare Agency ☐ Yes ☐ No	**Veteran** ☐ Yes ☐ No	**Receiving Snap** ☐ Yes ☐ No	**TANF** ☐ Yes ☐ No

#2 ADULT LIVING IN HOUSEHOLD - Custody Order/Agreement: □Yes □No □ No additional adult in the household

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** ☐ Male ☐ Female	**SSN**	
Race ☐ Asian ☐ Black ☐ White ☐ Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Multi-Racial	**Hispanic** ☐ Yes ☐ No **English Proficiency** ☐ None ☐ Little ☐ Moderate☐ Proficient	**Other Language** **Proficiency** ☐ Poor ☐ Moderate ☐ Proficient	**Veteran** ☐ Yes ☐ No	**Health Insurance** ☐ Medicaid ☐ Private Insurance ☐ No Insurance ☐ Other
Highest Grade Completed ☐ Master's ☐ Grade 11 ☐ Associate's ☐ Grade 10 ☐ Bachelor's ☐ <Grade 9 ☐ College Degree/Training ☐ College or Advance Training ☐ GED ☐ HS Graduate ☐ Grade 12	**Employment Status** ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Full Time & Training ☐ Part Time & Training ☐ Training or School ☐ Retired or Disabled ☐ Unemployed	**Employer's Name** ______________________ **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	
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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-*500* ☐ A1 - Homeless-*500*	☐ A2-Returning HS or EHS -*500* ☐ A3- SNAP-*500*	☐ B1 - Verified Disability of Child -*500* • Speech, developmental, etc. • (need documentation)
☐ B2 - Drug Dependency w/ Eligible Child	☐ B3 - History of Domestic Violence	☐ B4 - Substance Abuse
☐ B5 - Mental Health Concerns of Individual or Family Members	☐ 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 member)	☐ B12 - Teen Parent (under age of 18)	☐ B13 - At Risk Pregnancy (pregnant mom applicant only)
☐ B14 - First Pregnancy (pregnant applicant only)	☐ B15 – Single Parent/ Grandparent/ Kinship Care/Family Care	☐ B16 – Military Service (parent or guardian)
☐ B17 - Lack GED or High School Diploma	☐ 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 5 yrs. or more than 4 in household.	☐ B25 - Lack of Affordable Childcare	☐ B26 - Physical/Social Isolation
☐ B27 - Incarcerated Immediate Family Member	☐ B28 - Overwhelmed by Raising Child(ren)	☐ B29 – Family has moved more than twice in past 12 months.

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**
A6. ☐ Infant ______	A4. ☐4-year-old ____ ☐ 5-year-old (document required)
A6. ☐ Toddler _____	A5. ☐ Transition EHS 3-year-old ___
A7. ☐ Pregnant Woman _____	A8. ☐ 3-year-old ____

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

Updated Feb 2023