



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

<input type="checkbox"/> Head Start		<input type="checkbox"/> Early Head Start - Child		<input type="checkbox"/> Early Head Start – Pregnant Mom Due: Date ___/___/___	
Child's Name (First, Middle, Last, Suffix)		Nickname	DOB	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN
Race <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other _____		Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No		Any Other Language?	
		English Proficiency <input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		Other Language Proficiency <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient	
Primary Health Coverage <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> No Health Insurance <input type="checkbox"/> Other	Medicaid Eligibility <input type="checkbox"/> Not Eligible <input type="checkbox"/> On Medicaid <input type="checkbox"/> 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: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other			Parent/Guardian Name: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other		
Phone Number: _____			Phone Number: _____		
Email: _____			Email: _____		
Current Day Care Provider: Name: _____ Address: _____					
Previous Day Care Provider: Name: _____ Address: _____					
Is child also enrolled in another program/school? <input type="checkbox"/> Yes, Name of Program: _____ <input type="checkbox"/> No					
Info: (check all that apply) <input type="checkbox"/> Food Stamps <input type="checkbox"/> Access to Auto <input type="checkbox"/> TANF Recipient <input type="checkbox"/> Homebound Senatorial District: <input type="checkbox"/> Franklin County: or <input type="checkbox"/> Patrick County: 15 19 20 <input type="checkbox"/> Other House District: <input type="checkbox"/> Franklin County: or <input type="checkbox"/> Patrick County: 9 14 16 <input type="checkbox"/> Other Home Heating Source: <input type="checkbox"/> Electric <input type="checkbox"/> Fuel/oil <input type="checkbox"/> Kerosene <input type="checkbox"/> LPG/propane <input type="checkbox"/> Natural gas <input type="checkbox"/> Solar energy <input type="checkbox"/> Wood Ever Experienced a Housing Crisis? <input type="checkbox"/> Yes <input type="checkbox"/> No Benefit from Financial Counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No Benefit from Parental Counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No Where did you hear about us? _____ Would you like to be referred or receive information about other STEP programs? <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN
Race <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other _____	Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Language Proficiency <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient	Health Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> No Insurance <input type="checkbox"/> Other	
	English Proficiency <input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient			
Highest Grade Completed <input type="checkbox"/> Master's <input type="checkbox"/> Associate's <input type="checkbox"/> Bachelor's <input type="checkbox"/> College Degree/Training <input type="checkbox"/> College or Advance Training <input type="checkbox"/> GED <input type="checkbox"/> HS Graduate <input type="checkbox"/> Grade 12 <input type="checkbox"/> Grade 11 <input type="checkbox"/> Grade 10 <input type="checkbox"/> <Grade 9	Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Full Time and Training <input type="checkbox"/> Part Time & Training <input type="checkbox"/> Training or School <input type="checkbox"/> Retired or Disabled <input type="checkbox"/> Unemployed	Employer's Name _____ Employer's Address _____ Employer's Phone Number _____		
Primary Language at Home _____	Homeless Family <input type="checkbox"/> Yes <input type="checkbox"/> No	WIC <input type="checkbox"/> Yes <input type="checkbox"/> No	SSI <input type="checkbox"/> Yes <input type="checkbox"/> No	
Referred by Child Welfare Agency <input type="checkbox"/> Yes <input type="checkbox"/> No	Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No	Receiving Snap <input type="checkbox"/> Yes <input type="checkbox"/> No	TANF <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN
Race <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Multi-Racial	Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Language Proficiency <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient	Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No	Health Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> No Insurance <input type="checkbox"/> Other
	English Proficiency <input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient			
Highest Grade Completed <input type="checkbox"/> Master's <input type="checkbox"/> Grade 11 <input type="checkbox"/> Associate's <input type="checkbox"/> Grade 10 <input type="checkbox"/> Bachelor's <input type="checkbox"/> <Grade 9 <input type="checkbox"/> College Degree/Training <input type="checkbox"/> College or Advance Training <input type="checkbox"/> GED <input type="checkbox"/> HS Graduate <input type="checkbox"/> Grade 12	Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Full Time & Training <input type="checkbox"/> Part Time & Training <input type="checkbox"/> Training or School <input type="checkbox"/> Retired or Disabled <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN
Race <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Racial		Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No English Proficiency <input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		Other Language _____ Other Language Proficiency <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient
Primary Health Coverage <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> No Health Insurance <input type="checkbox"/> Other		Other Coverage: _____	Currently In Child Care <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Current Provider: _____ Name of Previous Provider: _____	

ADDITIONAL CHILD Check if NO ADDITIONAL CHILDREN

Name (First, Middle, Last, Suffix)		DOB	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN
Race <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Racial		Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No English Proficiency <input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		Other Language _____ Other Language Proficiency <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient
Primary Health Coverage <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> No Health Insurance <input type="checkbox"/> Other		Other Coverage: _____	Currently In Child Care <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Current Provider: _____ Name of Previous Provider: _____	

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Primary Health Coverage <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> No Health Insurance <input type="checkbox"/> Other		Other Coverage: _____	Currently In Child Care <input type="checkbox"/> Yes <input type="checkbox"/> 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.)

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

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 \$ _____	<input type="checkbox"/> Income Eligible <input type="checkbox"/> 100% <input type="checkbox"/> 100-130% <input type="checkbox"/> Over Income
<input type="checkbox"/> Income verification included	<input type="checkbox"/> Birth verification included	<input type="checkbox"/> USDA Forms included	
Early Head Start A5. <input type="checkbox"/> Infant _____ A5. <input type="checkbox"/> Toddler _____ A6. <input type="checkbox"/> Pregnant Woman _____		Head Start A3. <input type="checkbox"/> 4-year-old ____ <input type="checkbox"/> 5-year-old (docu. required) A4. <input type="checkbox"/> Transition EHS 3-year-old ____ A7. <input type="checkbox"/> 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:	