Family Application
Intake Form

Name of Center/Home Base			*Date of screening / /*
Name of Child	*Age*	*Sex*	*Date of Birth*
			/ /
CHILD'S RACE/ETHNICITY			
Tribal Member: ☐ Yes ☐ No		Indian Non-Tribal: ☐ Yes ☐ No	
Non-Indian: ☐ White ☐ Hispanic ☐ Black ☐ Asian/Pacific Islander			
FAMILY INCOME VERIFIED BY HEAD START STAFF			
The family is eligible ☐ The family is over income ☐			
FAMILY COMPOSITION			
Name of parent(s)/Guardian(s):			
Address:			
Age of Parents(s)/Guardian(s) Mother: Father:			
Other children in the Head Start Program ☐ Yes ☐ No, How Many?			
Number of extended family members in the house hold:			
Number of grand parents _____, Aunts _____, Uncles_____, Cousins _____, Others _____. List relationship of others:			
Special needs of the child as reported by the parent/guardian			
Special needs of the child as reported by the Head Start staff			
Family referred by (individual/agency name):			
OTHER SELECTION CRITERIA (check all that apply)			
☐ Family lives in remote area		☐ Child needs social interaction	
☐ AFDC family		☐ Foster care child	
☐ Single parent family		☐ Other factors:	
☐ Teenage parent(s)			
ACTION TAKEN ON THIS APPLICATION			
☐ Accepted for enrollment ☐ Rejected for enrollment			
☐ Accepted and placed on waiting list a priority number of:			
Reason for rejection:			

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Sex	Age	Birth date	
			Home Phone
Tribal Member: ☐ CDIB#: Tribe:	Indian Non-Tribal: ☐ CDIB#: Tribe:		Work Phone Mother: Work Phone Father:
Non-Indian ☐ White ☐ Hispanic ☐ Black ☐ Asian/Pacific ☐ Other(List)			Address:

EMERGENCY CARE ARRANGMENTS (2 adults other than parents)

1. Name: Address: Phone #: Relationship:	2. Name: Address: Phone #: Relationship:

EMERGENCY MEDICAL CARE

Name of Family Doctor: Phone #:
Location of Office:

FAMILY HOUSE HOLD COMPOSITION (other than child)

Names	Relationship to child	Age	Sex	Employed Yes or No	Level Education
1					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

STATUS OF APPLICATION

Date of Application: Date Approved for Enrollment: / / Waiting List #: / /
Date Child enrolled: Program Option☐ Center Base ☐ Home Base ☐
Over Income: ☐ Income Eligible: ☐ Child Disabled ☐
Child Termination ☐ Date:

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Name of Parent/Guardian:			ne of Child:	
Address:				
Total number of individuals living in house hold:				
Total number of individuals contributing taxable and non-taxable income:				
SOURCE OF TAXABLE INCOME				
Name of person with taxable income	Source of income	Gross amount of income with adjustments	Date verified	Documentation use to verify
SOURCE OF NON-TAXABLE INCOME				
Name of person with taxable income	Source of income	Gross amount of income	Date verified	Documentation use to verify
Total of gross taxable and non-taxable income:				
The Head Start income guidelines For a family this size is: #		This family is income eligible	☑ Yes	☐ No
The Head Start program shall verify the family income before determining that a child is eligible to participate in the program. No child can be enrolled until a Head Start staff verifies all income. The Head Start staff who verifies the gross family income must sign this form.				
Signature of staff verifying income:			Date: / /	