



Belknap-Merrimack Head Start/Early Head Start

For Office Use ONLY
Center/Classroom _____
Program Option _____
Program Year _____

Enrollment Application

Applicant (child): Name: _____ Date of Birth: _____ Gender: M ___ F ___

Health Insurance: None: ___ Medicaid: _____ Private: _____ Insurance # _____

Hispanic: Yes ___ No ___ Race: (check one) ___ Black ___ White ___ Asian
___ Hawaiian/Pacific Islander ___ American Indian/ Alaskan Native ___ Multi-Racial Other _____

Special Concerns:

Does your child have a special need? Yes: ___ No: ___ Suspected: _____

Speech and language impairment: _____ Emotional/ Behavioral disorder: _____

Health Conditions (describe): _____

Medications: _____

Has your child been evaluated by early supports and services? _____

Does your child have an IFSP (Individual Family Service Plan) and receive services? _____

Have you applied to the local school and receive special education services? _____

Does your child have an IEP (Individual Education Plan)? ___ If yes, what school district? _____

Were you referred to us by an agency, physician, or program? _____ If yes, by whom? _____

Interested In:

Head Start Pre-school (ages 3-5):

- _____ Part Day Pre-school (no cost)
- _____ Full Day Wrap Around Childcare (low cost Concord and Laconia only)
- _____ Home Based (very limited)

Early Head Start (ages 0-3):

- _____ Home Based Services (no cost)
- _____ Center Based, Full Day, low cost Childcare (Concord and Laconia only)

Please note that Full Day Spots are limited and not guaranteed even if eligibility requirements are met

Do you currently receive the NH Childcare Scholarship through DHHS? _____ Yes ___ No

Is your child currently in a child care program? ___ Yes ___ No, If Yes, where? _____

Demographic Information

of parents in home: ___ Primary Language(s) spoken in home: _____

Are you learning a language in addition to English?: _____. Do you require an interpreter? _____

Do you have transportation to get your child to school? yes no

***Head Start does not provide transportation**

Parent/Guardian Information

Parent/ Guardian #1: _____ **D.O.B.** _____ **Gender: M: ___ F: ___**

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Mailing if different: _____ **Phone:** _____

Email: _____ **Hispanic: Yes: ___ No: ___** **Race (please circle):** Black, White, Asian, Hawaiian/Pacific Islander, American Indian/Alaskan Native, Multi-Racial, Other _____

Education Level

- ___ **Less than Highschool Graduate**
- ___ **Highschool Graduate/ H/ GED**
- ___ **Some college/vocational/associate's degree**
- ___ **Bachelor's Degree or Advanced**

Employment Status

- ___ **Full Time**
- ___ **Part-time**
- ___ **Seasonal**
- ___ **Unemployed**
- ___ **Retired or Disabled**
- ___ **Job training/school**
- ___ **Military? Active Duty/Guard or Veteran**

Provides Financial Support? Yes or No

Relationship to Child

- ___ **Biological/Adopted/ Step-Parent by marriage**
- ___ **Grandchild,**
- ___ **Relative other than Grandchild**
- ___ **Foster**
- ___ **Other** _____

Custody

- ___ **Yes**
- ___ **No**
- ___ **Guardianship**
- ___ **DCYF Placement**

Lives with Child? Yes or No

Parent/ Guardian #2: _____ **D.O.B.** _____ **Gender: M: ___ F: ___**

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Mailing if different: _____ **Phone:** _____

Email: _____ **Hispanic: Yes ___ No ___** **Race (please circle):** Black, White, Asian, Hawaiian/Pacific Islander, American Indian/Alaskan Native, Multi-Racial, Other _____

Education Level

- ___ **Less than Highschool Graduate**
- ___ **Highschool Graduate/ HiSET/ GED**
- ___ **Some college/vocational school/associate degree**
- ___ **Bachelor's Degree or Advanced**

Employment Status

- ___ **Full-Time**
- ___ **Part-time**
- ___ **Seasonal**
- ___ **Unemployed**
- ___ **Retired or Disabled**
- ___ **Job Training/School**
- ___ **Military? Active Duty/Guard or Veteran**

Provides Financial Support? Yes or No

Relationship to Child

- ___ **Biological/Adopted/Step-Parent by marriage**
- ___ **Grandchild,**
- ___ **Relative other than Grandchild**
- ___ **Foster**
- ___ **Other** _____

Custody

- ___ **Yes**
- ___ **No**
- ___ **Guardianship**
- ___ **DCYF Placement**

Lives with Child? Yes or No

Additional Household Members (note whether you financially support each person or not)

Name	DOB	Gender	Relationship

Family Circumstances

Please Check All that Apply

Mental Health Services		Incarcerated parent		2 or more children under age 3	
Disabled Family Member		Current teen parent		Single parent	
History of Substance Abuse		New American Family		My Child has a doctor	
DCYF involvement (In the past year)		Non-high school graduate		My Child has a dentist	
History of Domestic Violence		Non-English speaking		Parent/Guardian in Military	

Are you currently experiencing homelessness? ___ Yes ___ No

If yes, please circle which best describes your child's primary nighttime residence:

- ◆ **Temporarily sharing housing with others (family, friends, etc.) due to loss of housing, economic hardship, or similar reason**
- ◆ **Hotel/Motel**
- ◆ **Campground**
- ◆ **Emergency/Transitional Shelter**
- ◆ **Other _____**

Referred by DCYF? ___ Yes ___ No Are you currently receiving SNAP/EBT? ___ Yes ___ No

Receiving WIC? ___ Yes ___ No Are you currently receiving TANF? ___ Yes ___ No

Receiving SSI? ___ Yes ___ No

Is your family in need or having a specific crisis (please describe)?

Family Income

Income by family member	Gross amount (before taxes)	Time period (monthly, weekly, bi-weekly etc.)	Source of income (employer, TANF, SSDI, etc)

Income verification for the last 12 months- Please Provide ONE of the Following

- ◆ ___ TANF or SNAP Letter
- ◆ ___ Social Security Letter
- ◆ ___ Tax Return 1040 or W2 Forms (preferred form of documentation if no SNAP, TANF, or SSI)
- ◆ ___ Paystubs for 4 consecutive weeks (if paid weekly: 4 paystubs. If paid bi-weekly: 2 paystubs for all jobs)
- ◆ ___ Unemployment Information
- ◆ ___ Written Statement from Employer
- ◆ ___ SSDI and/or VA Disability

Age verification- Please Provide ONE of the Following

- ◆ ___ Immunization Record
- ◆ ___ Birth Certificate
- ◆ ___ Insurance Card DOB

For Office Use Only

Total Yearly income:

\$ _____

Certification: I hereby certify that the information I have provided on this application is complete to the best of my knowledge and provides a true summary of my income and needs. I understand that I am required to provide documentation or other verification to provide the sources of my income.

Parent/ Guardian signature_____
Date

Assurance of Confidentiality: The information you provide will help us deliver or direct services most appropriate for your family's needs. All information will be held in strict confidence.

Return to: The center nearest to you OR E-mail to: headstart@capbm.org

**Mail to: Community Action Program Belknap/Merrimack Counties,
P.O. Box 1016
Concord NH 03302-1016
Phone: 603-225-3295 ext. 1127
Fax: 603-228-1898**

Program staff interview:

 In person

 On telephone due to: _____

Staff printed name: _____

Staff Signature: _____ **Date:** _____

For Office Use Only

Enrollment Staff Certification: I hereby certify that I have seen and reviewed the income documentation or other forms of verification identified in this application. No information has been intentionally altered or omitted. I understand that actions may be taken which may affect my employment at Belknap-Merrimack Head Start/ Early Head Start for intentionally submitting false information.

Enrollment Staff Signature _____
Date

Enrollment staff printed name

Second look staff signature _____
Date

Income eligible Foster Child Public Assistance Homeless Over income

Date waitlisted _____ Letter sent _____ Date accepted _____ Letter sent _____