Belknap-Merrimack Head Start/Early Head Start

For Office Use Only
Center/Classroom_____
Program Option_____
Program Year_____

Application for Enrollment

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 for Special Education Services? _____

Does your child have an **IEP** (Individual Education Plan)? _____ If yes, which 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)

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? _

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:

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
☐ Bachelors Degree or Advanced

Employment Status

☐ FullTime
☐ Part-time
☐ Seasonal
☐ Unemployed
☐ Retired or Disabled
☐ Job Training/School

Military: Active Duty/Guard or Former (Veteran)

Provides Financial Support? ☐ Yes ☐ No

Relationship to Child

☐ Biological/Adopted/Step-Parent
☐ Grandchild,
☐ Relative other than Grandchild
☐ Foster
☐ Other_____

Custody

☐ Yes
☐ No
☐ Guardianship
☐ DCYF Placement

Lives with Child? ☐ Yes ☐ No

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

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

Mailing if different: _____ Phone: _____

Email: _____ Hispanic: Yes: ☐ No: ☐ Race:

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
☐ Bachelors Degree or Advanced

Employment Status

☐ Full Time
☐ Part-time
☐ Seasonal
☐ Unemployed
☐ Retired or Disabled
☐ Job Training/School

Military: Active Duty/Guard or Former (Veteran)

Provides Financial Support? ☐ Yes ☐ No

Relationship to Child

☐ Biological/Adopted/Step-Parent
☐ Grandchild,
☐ Relative other than Grandchild
☐ Foster
☐ Other_____

Custody

☐ Yes
☐ No
☐ Guardianship
☐ DCYF Placement

Lives withChild? ☐ Yes ☐ No

Additional Household Members

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 (current or former)	☐	Non high school graduate	☐	My child has a dentist	☐
History of Domestic Violence	☐	Non-English speaking	☐	Parent or guardian military(veteran/ current)	☐

Are you currently experiencing homelessness? ☐ Yes ☐ No

If homeless, 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

Is your family in need or having a specific crisis? _____

If yes, please describe_____

Family Income

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

Income verification type- Please Provide ONE of the Following

- ◯ TANF or SNAP Letter
- ◯ Social Security Letter
- ◯ Tax Return or W2 Forms
- ◯ Paystubs for 4 consecutive weeks (if paid weekly provide 4 paystubs, if paid bi-weekly provide 2 paystubs)
- ◯ Unemployment Information
- ◯ Written Statement from Employer
- ◯ SSDI and/or VA Disability

Age verification type- 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 Email to Headstart@**capbm.org**

OR mail to: Community Action Program Belknap/Merrimack Counties, Inc
PO Box 1016
Concord NH 03302-1016
Phone: 603-225-3295
Fax: 603-228-1898

Program staff interview:

___In person
___On telephone due to:_____

Staff printed name: _____

Staff Signature: _____ Date: _____

For Office Use

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_____