

Allegany County Human Resources Development Commission, Inc.
Head Start/Early Head Start
125 Virginia Avenue
Cumberland, MD 21502
301-783-1730

FAX#: 301-876-9081 TTY/TDD 1-800-982-9877

APPLY TODAY! ☺

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Primary Adu								_		check all th	
☐ Head Start	□ Head Start Child (3,4 &5 yrs) □ Early Head Start(birth-2yrs) □ Early Head Start Pregnant Women										
Child Applicant Information Last First MI Preferred Suffix											
Last						MI		Preferred	Suffix		
Birthday			Gender								
Dirtiiday			SSN			Male Female					,
Address/Phone											
Living Address					Mailii	ng Address	(if diff	erent tha	ın liv	ring)	
Living Address l	Line 2				Mailii	ng Address	Line 2				
City		State	Zip	Co.	City				State	e Zi _I)
Phone Code:	H- Home	C- Cel	M- Mess	age	Note:	Fill in Emai	il for AI	L individ	duals	where applica	able.
Phone Code: H- Home C- Cell M- Message P- Pager/Beeper W- Work Note: Fill in Email for ALL individuals where applicable.											
Phone Code		Phone	Number		√ If Pı	■ Enter email If wish to be contacted by Email.					
	()	-				Email-					
	()	-			2 nd Email						
				Applica	nt Hea	lth Cover	rage				
Medicaid Eligibi	ility Status:	□ On M	edicaid 🗆 🛚 Potentially E	Not Eligibl ligible	le		Medio	caid Nun	ıber		
Primary Health	Coverage		Other	Health Co	verage Insurance Number				ımber		
Name of Primar	y Physician				Nai	ne of Prim	ary De	ntist			
			Chile	d Applic	ant De	mograph	ics				•
Race/Check all	l that			√if Pr							
Applies		Lan	guage			Proficiency		ncy		Profici	ency Language Code
AsianBlackWhiteNative Ame	erican	En	glish								0-None 1-Poor Moderate -Proficent
 Pacific Isla 	nder										
O Other											
Nationality						Ethnicity	,				

VERY IMPORTANT

You MUST send copies of the following items with this registration in order for it to be processed.

- 1) **PROOF OF INCOME** (all that are checked in the Income source box)
- 2) CHILD'S SOCIAL SECURITY CARD
- 3) CHILD'S BIRTH CERTIFICATE
- 4) UPDATED IMMUNIZATION RECORD
- 5) COMPLETED PHYSICAL BY PHYSICIAN

You may send a copy of your Federal Income Tax form for the most recent tax year or three (3) consecutive pay stubs or unemployment pay stubs. For Public Assistance or other benefits, you must submit a copy of your award letter. For child support or alimony, you must submit a copy of the court order or copies of three (3) consecutive checks. All children must be up to date on their shots, have a current physical and recent screening from the dentist.

Primary Adult Member Information (Complete for each non-applicant family member)

☐ Primary Adult											
Last Name	F	First Name	!				Middl	le	Preferred	Suffix	
Birthday	SSN						Gender: Male Female				
Lives with Family? □ Yes □ No				Provides Financial Support □ Yes □ No							
Child's Relationship Code: C- Natural/Adopted/Step ; F- Foster ; G- Grandchild N- Niece/Nephew ; O- Other				Highest Grade Completed Code: □ COL- College/Advance Training □ G9-Grade 9 or less □ CTG- College Degree /Training Certificate □ G-10 □ G-11 □ G-12 □ HSG-High School Grad □ GED□A-Associate's Degree □ B-							
Relationship to Child?					HSG-High Degree □ N				A-Associate's I	Degree □B-	
Do you have custody? ☐ Yes ☐ No					Grade Co		eted	Teen l □Yes	Parent? □No		
Present Employment Status Code: F-Full Time (35hr.wk) B-Full Time and Training P-Part Time L-Part Time and Training R- Retired or Disabled S- Seasonally Employed T- Training or School U- Unemployed				Present Employment Status: Subsidized Yes						0	
		Primary A		Hea	lth Cove						
Medicaid Eligibility Status: □ On Medicaid □ Not Eligible Medicaid Number □ Potentially Eligible											
Primary Health Coverag	e		alth Coverage I				Insur	Insurance Number			
Name of Primary Physician	<u> </u>		Name of Primary Dentist								
					nographics						
Race/Check all that Applies	Language		if Prima	ary		Prof	iciency			y Language ode	
 Asian Black White Native American 	English								1-F 2-Mo	lone Poor derate oficent	
Other											
US Citizen □Yes □No If no	o where?	Prima	rv Adult	's Em	Ethnicity Inloyment	•					
I am currently working, attending school or am in training I am currently working, he long have you been at your current job?							th	Is transportation an on going problem for your family?			
☐Yes ☐No If yes please specify where:	How Long	g	_		□Yes		lo		☐Yes If yes, wh	No y?	
	Where		-								

Secondary Adult Member Information (Complete for each non-applicant family member)

□Secondary Adult										
Last Name	First Name					Middle	Prefe	erred	Suffix	
Birthday	1	SSN		Gender: □ Male					e 🗆 Female	
Lives with Family?	Provides Financial Support ☐ Yes ☐ No									
Child's Relationship Co- C- Natural/Adopted/Ste N- Niece/Nephew ; O- O	Highest Grade Completed Code: □ COL- College/Advance Training □ G9-Grade 9 or less □ CTG- College Degree /Training Certificate □ G-10 □ G-11 □ G-12 □ HSG□GED□A-Associate's Degree □B-Bachelor's Degree									
Relationship to Child?			☐ G-12 ☐ M-Mas			ssociate's I	egree □I	B-Bachelo	r's Degree	
Do you have custod ☐ Yes ☐ No	y ?		Highest	Grade	Complet		en Pare Zes 🗆	ent? No		
Present Employmer F-Full Time (35hr.wk) P-Part Time L-Part Retired or Disabled S- Seasonally Employee U- Unemployed	☐ B-Full Time a Time and Trainir	nd Training ng □R-	Present Status:	Employ	yment		bsidized Zes	d: □ N	lo	
		Secondary	Adult's H	Iealth C	Coverage	;				
Medicaid Eligibility Stat	tus: 🗆 On Medica		ligible Medicaid Nu				ımber			
Primary Health Coverage	Primary Health Coverage Other Healt									
Name of Primary Physic	ian		Name of Primary Dentist							
		Seconda	ry Adult's I	D emograp	hics					
Race/Check all that Applies	Languag		if Primary]	Proficiency	Ÿ]		y Language ode	
Asian Black White Native American	English	ı						1-I 2-Mo	None Poor derate oficent	
Pacific IslanderOther										
Nationality	ı			Ethni	city					
		Second	ary Adult's							
I am currently working, attending school or am in training	If currently work how long have your curiob?	rking, I h you con rrent	ave a severe idition		Is transp	oortation a problem faily?		Notes:		
☐Yes ☐No If yes, please specify where:	How Long?		□Yes □No □Yes If yes			es □No ves, why?	-	Not	tes:	

Child Family Member #1 (Complete for each non-applicant family member)

Last		First					MI Preferred Suffi					
Birthday		SSN					Gender Ma	ale Female	!			
	'		CLUB H	шс			•					
Medicaid Eligibility Statu	ısı 🗆 On Madice	oid □ N	Child's Heal lot Eligible	Ith Co	verage	Medic	aid Number	•				
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Primary Health Coverage	e	Other 1	Health Cover	rage	Insurance Number							
Name of Primary Physician					Name of Primary Dentist							
		(Child's De	mogr	aphics							
Race/Check all that		`	√ if Prima	ary								
Applies	Languag	ge		·	Pro	ficiency		Profici	Proficiency Language Code			
o Asian									0-None			
BlackWhite	English								1-Poor Moderate			
WhiteNative American									Proficent			
o Pacific Islander												
o Other												
Nationality					Ethnicity	7						
		mplete fo	Child Family or each non-a			membe			T			
Last		First					MI	Preferred	Suffix			
Birthday		SSN		Gender Male					Female			
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Medicaid Eligibility Statu	ıs. 🗆 On Madics	oid □ N	Child's Heal lot Eligible	Ith Co	verage	Medic	aid Number	•				
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Primary Health Coverage	e	Other 1	Health Coverage				Insurance Number					
Name of Primary Physici	an	l	Name of Primary Dentist									
			Child's De		phics							
Race/Check all that			√ if Prima	ary	_				-			
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WhiteNative American									Moderate Proficent			
o Pacific Islander			ļ						1 I oncent			
o Other												
Nationality		•			Ethnicity	7						

In order for us to plan our program to meet the needs of our families, you could be very helpful by providing the information below. Indicate the option that best meets your needs. Unfortunately, we cannot guarantee that the times you mark will be available.

Morning only from AM to PM

□ Morning only from _			
Afternoon only from	Who takes care of your chi	id after nead Start:	
		ld in the morning?	
	on fromAM to		
□Evening and afternoo	M to DM	_ ^{Γ [V]}	
	Vho takes care of you child	d during the summer?	
V	Tho takes care of you clind	u during the summer:	
	child for 9 months or 12 m akes care of you child duri		□ 12 months
your home? A Home Ba	sed teacher would visit yo	our home once a week t	onalized learning program in to be with you and your child experience . □ yes □ no
If ves, when would vou l	like your personalized pro	ogram?	
	☐ daytime or		om.
□ Saturdays	☐ daytime or	□ evenings after 5	pm.
•	art Program further assist	_	
Please check all that app			
☐ Provide infant and too ☐ Provide before school What areas would you be	dcare in the community and ddler childcare at the Head care at the Head Start ce	ad Start center. enter for my school age	children.
☐ Provide infant and too ☐ Provide before school What areas would you be	ddler childcare at the Heal care at the Head Start ce interested in obtaining info Reading Skills	nd Start center. enter for my school age prmation about? Basic Math Skills	children.
☐ Provide infant and too ☐ Provide before school What areas would you be ☐ Employment	ddler childcare at the Head care at the Head Start ce	nd Start center. enter for my school age prmation about? Basic Math Skills	children.
☐ Provide infant and too ☐ Provide before school What areas would you be ☐ Employment	ddler childcare at the Heal care at the Head Start ce interested in obtaining info Reading Skills	nd Start center. enter for my school age prmation about? Basic Math Skills	children.
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ChildPlus Fa				Ch. J.		al Informa				
Application	#			Snaded	i boxes will	be completed b	y ager	icy staii		
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What is your Who is your										
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Are you enr	olled in	WIC?		1	Yes	No				
Has your do	ctor ind	icated t	hat 1			No				
is a high-risl										
Have you be			notl	her	□ Yes □	No				
Doctor or Sp	pecialist	?								
Do you have	a child	current	lv e	nrolled in th	e prograi	n? □				
Yes □ No			J		1 10	. —				
Primary Site	e		_	rental Statu		Prima	ry La	nguage	At Home	
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	1	1			Family In			Г		1
Family Member	Date	Sour	ce	Amount	How Often	Annual Am	ount	Туре	Description	Verification
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Seb-Subsidize	<u> </u>	BB- B0C	iai oc	curry		LL- Emplo	yer Le	tter	17114- 17114	•
Certification:										
program may										
this application		e held i	n stri	ict confidenc	e within the	ne agency an	d is a	ccessible	e to me during	g normal
business hou	rs.									
Parent / Guar	dian Sig	nature						Date		
This child is	income	eligible	for	Head Start/	Early He	ad Start	Yes_		No	_ (check one)
Varifying St	off Mon	hor						Det	0	
Verifying St	ali wien	iner						Dat	C	