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! ☺

Primary Adult Name: _____ I am applying for: (check all that apply)
□ 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
Birthday	**SSN** - -	**Gender** Male Female		

Address/Phone

Living Address				Mailing Address (if different than living)		
Living Address Line 2				Mailing Address Line 2		
City	State	Zip	Co.	City	State	Zip
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 Primary #**	**Enter email If wish to be contacted by Email.**	
	( ) -				**Email-**	
	( ) -				**2nd Email**	

Child Applicant Health Coverage

Medicaid Eligibility Status: □ On Medicaid □ Not Eligible □ Potentially Eligible		Medicaid Number
Primary Health Coverage	Other Health Coverage	Insurance Number
Name of Primary Physician	Name of Primary Dentist	

Child Applicant Demographics

Race/Check all that Applies	Language	√ if Primary	Proficiency	Proficiency Language Code
○ Asian ○ Black ○ White ○ Native American ○ Pacific Islander ○ Other	**English**			**0-None** **1-Poor** **2-Moderate** **3-Proficent**
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	**First Name**	**Middle**	**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** _____ **Relationship to Child?**	**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-Bachelor's Degree □ M-Master's Degree**

Do you have custody? □ Yes □ No	**Highest Grade Completed**	**Teen Parent?** **□Yes □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 □ No**

Primary Adult's Health Coverage

Medicaid Eligibility Status: □ On Medicaid □ Not Eligible □ Potentially Eligible		**Medicaid Number**
Primary Health Coverage	**Other Health Coverage**	**Insurance Number**
Name of Primary Physician	**Name of Primary Dentist**	

Primary Adult's Demographics

Race/Check all that Applies	Language	√ if Primary	Proficiency	Proficiency Language Code
○ Asian ○ Black ○ White ○ Native American ○ Pacific Islander ○ Other	**English**			**0-None** **1-Poor** **2-Moderate** **3-Proficent**
US Citizen □Yes □No If no where?			**Ethnicity**	

Primary Adult's Employment

I am currently working, attending school or am in training	If currently working, how long have you been at your current job?	I have a severe health condition	Is transportation an on going problem for your family?
□Yes □No **If yes please specify where:**	**How Long_____** **Where_____**	**□Yes □No**	**□Yes □No** **If yes, why?** **_____**

Secondary Adult Member Information

(Complete for each non-applicant family member)

□Secondary Adult				
Last Name	**First Name**	**Middle**	**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** **_____** **Relationship to Child?**	**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** **□ M-Master's Degree**

Do you have custody? □ Yes □ No	**Highest Grade Completed**	**Teen Parent?** **□Yes □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 □ No**

Secondary Adult's Health Coverage

Medicaid Eligibility Status: □ On Medicaid □ Not Eligible □ Potentially Eligible		**Medicaid Number**
Primary Health Coverage	**Other Health Coverage**	**Insurance Number**
Name of Primary Physician	**Name of Primary Dentist**	

Secondary Adult's Demographics

Race/Check all that Applies	**Language**	**√ if Primary**	**Proficiency**	**Proficiency Language Code**
o Asian o Black o White o Native American o Pacific Islander o Other	**English**			**0-None** **1-Poor** **2-Moderate** **3-Proficent**
Nationality			**Ethnicity**	

Secondary Adult's Employment

I am currently working, attending school or am in training	**If currently working, how long have you been at your current job?**	**I have a severe health condition**	**Is transportation an on going problem for your family?**	**Notes:**
□Yes □No **If yes, please specify where:**	**How Long? _____** **Where: _____**	**□Yes □No**	**□Yes □No** **If yes, why?** **_____**	**Notes:**

Child Family Member #1

(Complete for each non-applicant family member)

Last	First	MI	Preferred	Suffix
Birthday	**SSN**	**Gender** **Male Female**		

Child's Health Coverage

Medicaid Eligibility Status: □ **On Medicaid** □ **Not Eligible** □ **Potentially Eligible**		**Medicaid Number**
Primary Health Coverage	**Other Health Coverage**	**Insurance Number**
Name of Primary Physician	**Name of Primary Dentist**	

Child's Demographics

Race/Check all that Applies	**Language**	**√ if Primary**	**Proficiency**	**Proficiency Language Code**
o Asian o Black o White o Native American o Pacific Islander o Other	**English**			**0-None** **1-Poor** **2-Moderate** **3-Proficent**
Nationality			**Ethnicity**	

Child Family Member #2

Complete for each non-applicant family member

Last	First	MI	Preferred	Suffix
Birthday	**SSN**	**Gender** **Male Female**		

Child's Health Coverage

Medicaid Eligibility Status: □ **On Medicaid** □ **Not Eligible** □ **Potentially Eligible**		**Medicaid Number**
Primary Health Coverage	**Other Health Coverage**	**Insurance Number**
Name of Primary Physician	**Name of Primary Dentist**	

Child's Demographics

Race/Check all that Applies	**Language**	**√ if Primary**	**Proficiency**	**Proficiency Language Code**
o Asian o Black o White o Native American o Pacific Islander o Other	**English**			**0-None** **1-Poor** **2-Moderate** **3-Proficent**
Nationality			**Ethnicity**	

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**
Who takes care of your child after Head Start? _____
□ **Afternoon only from _____PM to _____PM**
Who takes care of your child in the morning? _____
□**Morning and afternoon from _____AM to _____ PM**
□**Evening from _____PM to _____PM**
Who takes care of you child during the summer? _____

Would you enroll your child for 9 months or 12 months? □ 9 months □ 12 months
If not 12 months, who takes care of you child during the summer? _____

As an option to a classroom program, would you consider having a personalized learning program in your home? A Home Based teacher would visit your home once a week to be with you and your child and a socialization day would be scheduled twice a month for playgroup experience . □ yes □ no

If yes, when would you like your personalized program?
□ **Weekdays** □ **daytime or** □ **evening after 5pm.**
□ **Saturdays** □ **daytime or** □ **evenings after 5pm.**

How could the Head Start Program further assist you with your current childcare needs?

Please check all that apply:
□ **Inform me about childcare in the community and how I can get the services I need.**
□ **Provide infant and toddler childcare at the Head Start center.**
□ **Provide before school care at the Head Start center for my school age children.**

What areas would you be interested in obtaining information about?
□ **Employment** □ **Reading Skills** □ **Basic Math Skills** □ **Parent skills**
Other _____.

Enrolled in Allegany County Board Of Education Pre-K?		□ **Yes** □ **No** **If yes, name of school _____** □**AM** □ **PM**	
Enrolled in Allegany County Board Of Education Special Education?		□ **Yes** □ **No** **If yes, name of school _____** □ **AM** □ **PM**	
Enrolled in Infants and Toddlers?		□ **Yes** □ **No**	
My pediatrician or I have concerns about my child's…		□ Speech □ Thinking □ Physical □ Development	
My child attends daycare:	Name:	Address:	□ Mon. □ Tues. □ Wed. □ Thurs. □ Fri.
I am in need of child care...	□ **Yes** □ **No**	□ **AM** □ **PM** **Both**	□ Mon. □ Tues. □ Wed. □ Thurs. □ Fri.

ChildPlus Family ID# _____
Application # _____

General Information

Shaded boxes will be completed by agency staff

For Pregnant Women

What is your due date? _____
Who is your OB/GYN?
Do you participate in Healthy Start? □ Yes □ No

Are you enrolled in WIC?
□ Yes □ No
Has your doctor indicated that this is a high-risk pregnancy? □ Yes □ No
Have you been referred to another Doctor or Specialist? □ Yes □ No

Do you have a child currently enrolled in the program? □ Yes □ No

Primary Site	**Parental Status: One / Two**	**Primary Language At Home**
Number in Family	**Number of Children_____ By age: 0-3 ___ 4-5____**	**Number in Household _____**

Family Income Support

CACFP Status: Full No/Little Reduced	**CACFP Date**	**CACFP Income**
TANF Status: □ Yes □ No	**SSI □ Yes □ No**	**WIC □Yes □ No**	**WIC Code:**

Family Income

Family Member	Date	Source	Amount	How Often	Annual Amount	Type	Description	Verification

Type Code	**Description Codes**	**Verification Codes**
ERN-Earned	**PEN-Pension SSI – SSD -**	**CS-Check Stub W2 – W2**
SUB- Subsidized	**SS- Social Security**	**EL- Employer Letter TAN- TANF**

Certification: I certify that this information is true. If any part is false, my participation in this agency's program may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent / Guardian Signature _____ Date _____

This child is income eligible for Head Start/Early Head Start Yes_____ No _____ (check one)

Verifying Staff Member _____Date___ _____