

Berkshire County Head Start Child Development Program, Inc.

2019-2020 Application

* If you need assistance filling out this application or have questions, please call 413-445-4162

Parent/Guardian's Name: _____ (DOB) _____
 (Head of Household/ Person filling out this application) (First, Middle & Last) Relationship to Eligible Child _____

Eligible Child's Full Name: _____ DOB: _____ Gender _____
 (First, Middle & Last)

Child's place of birth _____ Child's SSN _____

Additional Parent/Guardian's Name: _____ DOB: _____ Gender: _____
 (First, Middle, Last) Relationship to child _____

Contact Information for Child and Head of Household:

Address: _____
 # Street APT City ZIP CODE

Is your mailing address the same as your living address? **YES** **NO** If no, please list mailing address:

Address: _____
 # Street APT City ZIP CODE

Primary phone number _____

Cell phone _____

Work phone _____

Email: _____

We must have working numbers to reach families!

Person(s) we can call if we cannot reach the parent/guardian:

Name: _____

Number: _____

Name: _____

Number: _____

CHILD DATA

Child's race _____ Is the child Latino or Hispanic? _____

- Was the child previously enrolled in Early/Head Start? YES NO
- Has the child previously applied or been on the waiting list? YES NO
- What is the Primary Language spoken at home? _____ Child's English Fluency? Not at all Not well Well Very Well
- Does the child have an IFSP/IEP (or Disability)? YES NO

- Do you have any concerns about your child's health and/or development? YES NO

If yes, please describe:

PLEASE CHECK ALL THAT APPLY:

- | | | |
|---|--|--|
| <input type="checkbox"/> Active military deployment | <input type="checkbox"/> Suspected child abuse or neglect | <input type="checkbox"/> Parent(s) unemployed |
| <input type="checkbox"/> Family member smokes in the household | <input type="checkbox"/> Biological mother < 17 years old | <input type="checkbox"/> Parental substance abuse |
| <input type="checkbox"/> Language spoken at home other than English | <input type="checkbox"/> Family social disorganization | <input type="checkbox"/> Serious Health Issue |
| <input type="checkbox"/> Moved more than once in the last 12 months | <input type="checkbox"/> Maternal education < 8 th grade | <input type="checkbox"/> Family in the military |
| <input type="checkbox"/> Parental developmental disability | <input type="checkbox"/> Parent with less than a high school education | <input type="checkbox"/> Family member with a disability |
| <input type="checkbox"/> Poverty | <input type="checkbox"/> Recent Immigrant to the United States | <input type="checkbox"/> Family member currently in Head Start |
| | <input type="checkbox"/> Documented child abuse or neglect | <input type="checkbox"/> Teen mother |

Child Care: Berkshire County Head Start offers a child care option in Pittsfield, North Adams, and Great Barrington. We can provide child care before and/or after the morning program. We also offer a full day/full year child care option. There are fees for child care. Parents who are income eligible for Head Start may be eligible to apply for a child care subsidy to help with child care costs if funding is available. (Please indicate if you need full day care or before and after Head Start Care and if you already have a childcare voucher.)

DO YOU NEED CHILD CARE? _____ **DO YOU HAVE A CHILD CARE VOUCHER? Yes/No** _____ We can assist you in obtaining one

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Parent type: (check one) <input type="checkbox"/> Two Parent family <input type="checkbox"/> Single parent family(mother figure only) living with partner <input type="checkbox"/> Single parent family (mother figure only) <input type="checkbox"/> Single parent family(father figure only) living with partner Supportive <input type="checkbox"/> Single parent family (father figure only)	Family type: (check one) <input type="checkbox"/> Biological <input type="checkbox"/> DCF Supportive (Two parent) <input type="checkbox"/> DCF Slot (Foster) <input type="checkbox"/> DCF Supportive Slot (Single) <input type="checkbox"/> Foster Family <input type="checkbox"/> Other family type <input type="checkbox"/> Other relative(s)
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Types of Services or Financial Assistance received:

- | | |
|---|---|
| <input type="checkbox"/> Child Care Subsidies
<input type="checkbox"/> Fuel Assistance
<input type="checkbox"/> Foster Care/Adoption Subsidy
<input type="checkbox"/> Public Housing Assistance
<input type="checkbox"/> Supplemental Security Income (SSI)
<input type="checkbox"/> WIC | <input type="checkbox"/> Child support/Alimony
<input type="checkbox"/> Mass Health
<input type="checkbox"/> Public Assistance/Welfare
<input type="checkbox"/> SNAP- Food Stamps
<input type="checkbox"/> Unemployment Insurance |
|---|---|

Health Insurance: _____ **Doctor:** _____ **Dentist:** _____

Is your family homeless? YES NO **Have you been homeless in the last 12 months?** YES NO
(For the purpose of this form, your family is considered homeless if you are living with others because of financial need)

How did you hear about Head Start? _____

HOUSEHOLD FINANCES: Family employment and income information for the person(s) supporting the eligible child:

Number of adults in the household: ____ Number of children in the household: ____ Number of Adults contributing financially to the household: ____

Please Submit Income Information: attach current paystubs or proof of income

Head of Household Name: _____ Current Employer: _____

If you do not have an income, write "No Income" _____ and provide a letter explaining how you support yourself and family.

Statement of Parent/Guardian: I certify that information provided is correct to the best of my knowledge and is subject to verification. I am also aware that I may be subject to termination from the program if the information verified disqualifies me from eligibility. By signing this application I authorize Head Start to provide services: Vision, Blood Pressure, Hearing, Height and Weight, Speech and Language, Development (fine motor, gross motor, cognitive/verbal) and to release my child's records to the local school system.

Signature _____ Date _____

Name: _____	DOB _____	SSN _____	Gender _____	Relationship _____
<i>(First, Middle & Last)</i>				
Name: _____	DOB _____	SSN _____	Gender _____	Relationship _____
<i>(First, Middle & Last)</i>				
Name: _____	DOB _____	SSN _____	Gender _____	Relationship _____
<i>(First, Middle & Last)</i>				
Name: _____	DOB _____	SSN _____	Gender _____	Relationship _____
<i>(First, Middle & Last)</i>				

Office Use Only: Eligibility Determination Statement: I have examined the documents (checked) below and certify that the family is income-eligible in accordance with Head Start regulations and Eligibility-Selection-Enrollment-Attendance policies.

 Staff signature & date

