Berkshire County Head Start Child Development Program, Inc.

2020-2021 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 ☐
- Do you have any concerns about your child's health and/or development? ☐YES ☐NO
- Does the child have an IFSP/IEP (or Disability)? ☐YES ☐NO

If yes, please describe:

PLEASE CHECK ALL THAT APPLY:

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

- ☐ Two Parent family
- ☐ Single parent family(mother figure only) living with partner
- ☐ Single parent family (mother figure only)
- ☐ Single parent family(father figure only) living with partner Supportive
- ☐ Single parent family (father figure only)

Family type: (check one)

- ☐ Biological
- ☐ DCF Supportive (Two parent)
- ☐ DCF Slot (Foster)
- ☐ DCF Supportive Slot (Single)
- ☐ Foster Family
- ☐ Other family type
- ☐ Other relative(s)

Types of Services or Financial Assistance received:

- ☐ Child Care Subsidies
- ☐ Fuel Assistance
- ☐ Foster Care/Adoption Subsidy
- ☐ Public Housing Assistance
- ☐ Supplemental Security Income (SSI)
- ☐ WIC
- ☐ Child support/Alimony
- ☐ Mass Health
- ☐ Public Assistance/Welfare
- ☐ SNAP- Food Stamps
- ☐ 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_____
(*First, Middle & Last*)
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(*First, Middle & Last*)
Name: _____DOB_____SSN_____Gender_____Relationship_____
(*First, Middle & Last*)
Name: _____DOB_____SSN_____Gender_____Relationship_____
(*First, Middle & Last*)

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