**NORTHEAST SOUTH DAKOTA HEAD START PROGRAM, INC.**
**200 S Harrison St #1, Aberdeen, SD 57401 (605-229-4506)**
**2017-2018 FAMILY/CHILD ENROLLMENT APPLICATION**

## Participant 1 Name:

Birthdate: (Required) | Gender: Female_____ Male_____

Race: (Check all the apply)
___Asian ___Native American
___Black ___Pacific Islander
___White ___Other

Ethnicity:
___Hispanic
___Non-Hispanic

Nationality:

English Proficiency:
____ None ____ Little ____ Moderate ____Proficient
___Primary

Other Language Spoken: _____
____ None ____ Little ____ Moderate ____Proficient
___Primary

Medicaid: ___Yes ___No

Private Health Insurance: ___Yes ___No

Dental Insurance: ___Yes ___No

Doctor:
Phone Number:
City/State:

Dentist:
Phone Number:
City/State:

Diagnosed: Disability: ____Yes ____No IEP: ____Yes ____No

Food Allergy: ____Yes ____No Please Explain Allergy:

## Participant 2 Name:

Birthdate: (Required) | Gender: Female_____ Male_____

Race: (Check all the apply)
___Asian ___Native American
___Black ___Pacific Islander
___White ___Other

Ethnicity:
___Hispanic
___Non-Hispanic

Nationality:

English Proficiency:
____ None ____ Little ____ Moderate ____Proficient
___Primary

Other Language Spoken: _____
____ None ____ Little ____ Moderate ____Proficient
___Primary

Medicaid: ___Yes ___No

Private Health Insurance: ___Yes ___No

Dental Insurance: ___Yes ___No

Doctor:
Phone Number:
City/State:

Dentist:
Phone Number:
City/State:

Diagnosed: Disability: ____Yes ____No IEP: ____Yes ____No

Food Allergy: ____Yes ____No Please Explain Allergy:

## Primary Adult Name:

Birthdate: (Required) | Gender: Female_____ Male_____

Highest Grade Completed:

Employment Status:
____Full time ____Part Time
____Unemployed ____Retired
____Disabled ____ In School

___Lives with Family ___Provides Financial Support ___Teen Parent ___Subsidized

Email Address:

Relationship to Child: ☐ Custody

English Proficiency: ____ None ____ Little ____ Moderate ____Proficient

Other Language Spoken: _____
____ None ____ Little ____ Moderate ____Proficient

## Secondary Adult Name:

Birthdate: (Required) | Gender: Female_____ Male_____

Highest Grade Completed:

Employment Status:
____Full time ____Part Time
____Unemployed ____Retired
____Disabled ____ In School

___Lives with Family ___Provides Financial Support ___Teen Parent ___Subsidized

Email Address:

Relationship to Child: ☐ Custody

English Proficiency: ____ None ____ Little ____ Moderate ____Proficient

Other Language Spoken: _____
____ None ____ Little ____ Moderate ____Proficient

## Other Family Members Supported by the Income of the Parent(s) or Guardian(s)

| Adult/Child | Name | Birthdate | Gender |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## General Information

**Living Address** City State Zip Code County

Direction to home if a rural address:

**Mailing Address (If Different)** City State Zip Code

| Phone Numbers | Primary | Secondary | Notes: |
|---|---|---|---|
| Home - ( ) | ☐ | ☐ | |
| Cell- ( ) | ☐ | ☐ | |
| Cell- ( ) | ☐ | ☐ | |
| Work- ( ) | ☐ | ☐ | Work Place: |

Number in the Household: _____ Number in the Family Supported by the income of the Parent(s) or Guardian(s)_____

| Parental Status | Active Military Family | Primary Language at Home | Name of the Center/ Home Base Unit Applied For: |
|---|---|---|---|
| ☐One ☐Two | ☐Yes ☐No | | |

**Day Care Name**: **Address:** **Phone Number:**

**In the event the Parent(s)/Guardian(s) cannot be reached by telephone concerning the Health/Safety of a child(ren), the emergency contact person will be notified to assist in the Health/Safety of the child(ren).**

### Emergency Contacts (Other than Parent(s)/Guardian(s))

| | | | |
|---|---|---|---|
| Contact 1 | Name: | Relationship to Child: | ☐ Emergency Contact ☐ Release Child to |
| | Home Phone: | Cell Phone: | |
| Contact 2 | Name: | Relationship to Child: | ☐ Emergency Contact ☐ Release Child to |
| | Home Phone: | Cell Phone: | |

## Family Information

| TANF | SNAP | |
|---|---|---|
| ☐Yes ☐No | ☐Yes ☐No | ☐ SSI ☐ WIC ☐ Foster Child ☐ Homeless ☐ Referred |

| This Section to be Filled Out With the Parent/Guardian and Head Start Staff | | | | |
|---|---|---|---|---|
| Family Member | Annual Amount | Type[1] | Desc.[2] | Verif.[3] |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| 1. Type Codes | 2. Description Codes | 3. Verification Codes |
|---|---|---|
| **ERN**–Earned **SUB**–Subsidized | **PEN**–Pension **SSI**–SSI **SS**–Social Security | **CS**–Check Stub **W2**–W-2 **EL**–Employer Letter **TAN**–TANF TAX-1040 Tax Form CPA – Letter from Accountant |

**Income Check List:**

___W-2 (s)
___1040 Income Tax
___Recent Pay Stubs
___Unemployment Statement
___Court Ordered Child Support
___Financial Aid Grant/Scholarships
___Disability
___SSI
___SSA
___Foster Care
___Written Statement/Third Party Statement

**Income Notes:**

**If family has ZERO income, please explain how family is meeting their basic needs**

_____

_____

_____

The NESD Head Start Program, Inc. does not discriminate on the basis of race, color, national origin, age or disability in admission or access to, or treatment of employment in its programs and activities. The Section 504 Coordinator is the Human Resource/Technology Manager.

**I certify that all information I have provided is true and correct, and that all income is reported. I understand that this information is being given to determine eligibility and will be verified for accuracy. If any part is false, my participation with the Northeast South Dakota Head Start Program may be terminated. I understand that the information I provided in this application will be held in strict confidence.**

***I understand that completing this application does not guarantee my child's enrollment into the program**

**Parent/Guardian Signature**_____ **Date** _____

In-Person Interview_____ Telephone Interview_____

Please state the reason an in-person interview was not possible_____

_____

**Staff Signature** _____ **Date**_____