



APPLICANT (PREGNANT WOMAN OR CHILD) AND FAMILY INFORMATION

****ALL boxes must be completed****

Applicant Last Name:		First Name:		Date of Birth:	
Race: B = Black/African-American W = White A = Asian BM=Biracial/Multiracial (please explain) _____ N = American Indian or Alaskan Native P = Native Hawaii/ Other Pacific Islander O=Other: (please explain) _____					
Ethnicity: <input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic/Non-Latino		Sex: (circle one) F = Female M = Male			
Language of Family in Home		Example of Languages (not limited to these) : English / Spanish / Mixteco, Quichean/ Haitian – Creole, Patois/ Arabic, Hebrew, Hindi, Urdu, Bengali/ Chinese, Vietnamese, Tagalog/ Palauan Fijian/ German, French, Italian, Croatian, Yiddish, Portuguese, Russian/ Swahili, Wolol/ America Sign Language			
Address:			City/State: San Francisco, CA		
Zip Code:		Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell Phone		Work Phone:	
Parental Status: (circle one) O = Single Parent T = Two Parents (same household) F = Foster N = Not Child's Parent/Legal Guardian D=Joint Custody (two separate households)					
Number in Family:		Number of Children in Family: _____ by Age: 0-3 _____ 4-5 _____ (EHS) Pregnant Mothers: Due Date _____			
Type of Health Insurance: <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Healthy Families <input type="checkbox"/> None <input type="checkbox"/> Private (Name): _____ Health Insurance # _____			Primary Physician Name/ #: Dentist's Name/ #:		
How did you hear about Head Start? <input type="checkbox"/> family <input type="checkbox"/> friend <input type="checkbox"/> media <input type="checkbox"/> other: _____				Does child have a medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Please specify _____	
Housing: <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Public <input type="checkbox"/> Homeless Was your child ever enrolled in a childcare or preschool? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state name or agency: _____			Does your child currently have an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state condition: _____ Please attach IEP or IFSP to application		

FAMILY MEMBER INFORMATION

Members living in household who are financially supported by parent or guardian of the applying child and are related by blood, marriage or adoption							
ADULTS (those 18 and above)							
CODE	First and Last Name Enter Primary Adult First	Date of Birth	Social Security # (optional)	Sex	(D1) Edu Status	(D2) Empl Status	Occupation
A				M F			
B				M F			
C				M F			
D1 – Education years completed (insert codes in the section above marked D1) G09 = Grade 9 or less HSG = High School Graduate G10 = Grade 10 GED = GED G11 = Grade 11 COL = Some College, advanced training or Associates Degree G12 = Grade 12 B= Bachelor's Degree or Higher				D2 – Employment status (insert codes in the section above marked D2) F = Full-time (35 or more hours per week) P = Part-time (less than 35 hours per week) S = Seasonally employed U = Unemployed T = In training or school R = Retired or Disabled			
CHILDREN (For Pregnant Women applying for Early Head Start, include unborn child & estimated DOB)							
CODE	First and Last Name of the Child Enter Applicant First	Date of Birth	Social Security # (optional)	Sex	(D1) Child is related to	(D2) This child is	Participation Status
C01				M F			A N Y O
C02				M F			A N Y O E
C03				M F			A N Y O E
C04				M F			A N Y O E
D1 – Child is related to: (insert codes in the section above marked D1) A01 = First adult A02 = Only the second adult B01 = Not related B12 = Both adults		D2 – This child is: (insert codes in the section above marked D2) C = Natural or adopted child (includes stepchild) F = Foster child N = Niece or nephew G = Grandchild O = Other			Participation Status A = Applicant (child who is currently applying) N = Child too young but will be eligible next year Y = Child too young to be eligible next year O = Child too old for Head Start program E = Child currently enrolled in HS/EHS program		

Parent/Guardian PLEASE Read and Initial

_____ I will notify the agency immediately if there is any change in my income, family size, residence, employment, or reason for needing child development services.

_____ I understand that the information about my eligibility may be reviewed by representatives of the State of California, the Federal Government, independent auditors, or others as necessary for the administration and funding of the program

_____ I understand that this certification is not complete until all documentation is submitted and this form has been reviewed, signed, and dated by an agency representative and signed and dated by me.

I _____ Applications determined to be overcome will be shared with the San Francisco CEL Program.

_____ All State Preschool Site Waiting Lists* will be shared with the San Francisco CEL Program

I declare under penalty of perjury that the information I have provided to complete this Application is true and correct to the best of my knowledge.

Parent Signature: _____ Date: _____

Relationship To Child: Parent Grandparent Guardian Foster Parent Other: _____

Thank you for applying to the San Francisco Head Start /Early Head Start program~

Age Documentation:
 Birth Certificate Date of Birth: _____

INCOME (list all applicable adults in household)						
Family Member	(past 12 mths) MONTH/ YR	Income Doc	Family Member	(past 12 mths) MONTH/ YR	Income Doc	Past Calendar Year
A.	JANUARY	\$	B.	JANUARY	\$	A. \$
	FEBRUARY	\$		FEBRUARY	\$	
	MARCH	\$		MARCH	\$	
	APRIL	\$		APRIL	\$	
	MAY	\$		MAY	\$	
	JUNE	\$		JUNE	\$	
	JULY	\$		JULY	\$	B \$
	AUGUST	\$		AUGUST	\$	
	SEPTEMBER	\$		SEPTEMBER	\$	
	OCTOBER	\$		OCTOBER	\$	
	NOVEMBER	\$		NOVEMBER	\$	
	DECEMBER	\$		DECEMBER	\$	
TOTAL (gross or YTD income)		\$			\$	
	Public Assistance			Public Assistance		
A			B			Family Gross Income: \$\$
	X 12	\$		X 12	\$	

STAFF SECTION
HEAD START ELIGIBILITY WORKSHEET

SOURCE(S) OF INCOME

<input type="checkbox"/> Pay stubs (must reflect past calendar year or past 12 months) <input type="checkbox"/> Public Assistance Date: _____ Case# _____ <input type="checkbox"/> Income Tax W2 or 1040 <input type="checkbox"/> Foster care grant <input type="checkbox"/> Financial assistance <input type="checkbox"/> Veterans pension <input type="checkbox"/> Strike benefits/funds <input type="checkbox"/> Temporary assistance from needy family <input type="checkbox"/> Emergency money payments	<input type="checkbox"/> General Aid <input type="checkbox"/> Relief Money <input type="checkbox"/> Training Stipends <input type="checkbox"/> Alimony <input type="checkbox"/> Insurance or annuity <input type="checkbox"/> College grants, fellowships <input type="checkbox"/> Dividends, interest <input type="checkbox"/> Net rental/royalties <input type="checkbox"/> Trust or estates <input type="checkbox"/> Lottery winnings <input type="checkbox"/> Other _____
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Grantee Operated Centers/Programs for 2011-2012

Please mail or drop off your application directly to the center you are interested in attending. If you have any questions, feel free to call any of the Centers listed below. A Head Start/Early Head Start staff will be pleased to help you fill out the application or answer any questions.

Cadillac Head Start 316 Leavenworth San Francisco, CA 94102 .447.1384 Fax 776.0365	Potrero Hill Head Start 824 Carolina Street San Francisco, CA 94107 821.6639 Fax 821.6540
OMI Head Start 1111 Junipero Serra Blvd. San Francisco, CA 94132 337.0221 Fax 585.0433	Westside Head Start 2400 Post Street San Francisco, CA 94115 474.7637 Fax 474.7430
Southeast Head Start 1300 Phelps Street San Francisco, CA 94124 821.6005 Fax 647.7473	Sunnydale Head Start 1652 Sunnydale Avenue San Francisco, 94134 337-8407 Fax 337-7409
Ella Hill Hutch 1050 McAllister San Francisco, CA 94115 415.885.6547phone 415.885.6187 fax	Aleman Head Start 956 Ellsworth Street San Francisco, CA 94110 415-826-9548 Fax 474-7430
Kirkwood Head Start/Early Head Start 729 Kirkwood San Francisco, CA 94124 415-671-0859 Fax 671-1010	Early Head Start – (Home Base Option) 205 13 th Street Suite 3280 San Francisco, California 94103 For more information on this program, call, 415-405-0500 Fax 552-7257

In addition to the completed application we will need the following to determine eligibility:

1. Income Verification (Please attach one of the following documents)/to reflect the past twelve months or calendar year. One must be dated within the past 30 days from signature of this application.
 - ✓ Public Assistance Verification Letter (AFDC, TANF/Calworks, or SSI)
 - ✓ Pay Stubs to reflect the past 12 months or calendar year
 - ✓ Verified Letter from Employer
 - ✓ Unemployment Compensation (Claim letter or payment stubs)
 - ✓ W 2 or 1040 (The previous year of dated application)
2. Verification of Child's Age
 - ✓ Birth Certificate
 - ✓ Medi-Cal Card
 - ✓ Passport/Visa/Green Card
3. Proof of San Francisco City and County Residency
 - ✓ Utility Bill (PG&E, Cable, SBC)
 - ✓ Current Rental Agreement or Lease
4. Proof of school/training attendance (verified/certified schedule from school official)
5. For entry purposes, please also bring the following most recent documents.
 - ✓ Immunization (most current: yellow card, medical records, print out, etc.)
 - ✓ Medical exam (most current and within the past year)
 - ✓ TB test /screen with results (most current and within the past year)

2011 HHS Poverty Guidelines

Persons in Family	48 Contiguous States and D.C.	X < 130%	X > 130%
1	\$10,890	\$14,157	\$14,157.01
2	14,710	19,123	19,123.01
3	18,530	24,089	24,089.01
4	22,350	29,055	29,055.01
5	26,170	34,021	34,021.01
6	29,990	38,987	38,987.01
7	33,810	43,953	43,953.01
8	37,630	48,919	48,919.01