Early Head Start Application for Enrollment

Serving Pregnant Women, Infants and Toddlers up to age 3

I am applying for:
- ☐ Home Visiting Program (weekly visits)
- ☐ Center-Based
- ☐ First Available (Home Visiting or Center-Based)

Adult Name: ______________________ ______________ ☐ Father ☐ Mother ☐ ________
First MI Last — *Date of Birth* — *Other*

Address: ____
Street — *Apt. #* — *P.O. Box*

____
City — *State* — *Zip* — *County*

______________ ______________ ______________________
Phone 1 — *Phone 2* — *E-mail address*

This address is: ☐ House/Apartment ☐ Friend/Relative's House ☐ Motel/Shelter/Temporary Housing

Primary Language: ☐ English ☐ Spanish ☐ Other: ____________

Were you under 20 years old when your first child was born? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No If yes, due date: ____________

Were you referred by local agency (CPS, Foster care, WIC)? ☐ Yes ☐ No If yes, by whom: ____________

Family Income Information: Eligbility is based on child's age, family income, child's need, and available openings.

	Total Gross Income	Time Period of Total Income		Source of Income (check all that apply)		
Parent 1	$	☐ Weekly ☐ Monthly	☐ Bi-weekly ☐ Annually	☐ Working ☐ SSI	☐ Child Support ☐ Other:	☐ DHHS Financial
Parent 2	$	☐ Weekly ☐ Monthly	☐ Bi-weekly ☐ Annually	☐ Working ☐ SSI	☐ Child Support ☐ Other:	☐ DHHS Financial

Child 1 Name: ______________________ ______________ ☐ Male ☐ Female
First MI Last — *Date of Birth*

Child 2 Name: ______________________ ______________ ☐ Male ☐ Female
First MI Last — *Date of Birth*

Do any of the above children have a special need (IFSP) or a home visitor (Early On, health care visitor)? ☐ Yes ☐ No If yes, which child: ____________
Worker Name/Agency: ____________________

Other Family Members Living in Home:

Name	***Date of Birth***	***Relationship to Child(ren)***

Make additional notes regarding recent income changes, family size, or other concerns on the back of application.

I certify that the above information is correct and true to the best of my knowledge. I authorize the release of this information and educational records to be shared between EightCAP, Inc. 0-5 Head Start and any Intermediate School District.

Signature: ______________________ **Date:** ____________

Return application to: **Early Head Start** **5827 Orleans Rd, Orleans, MI 48865** **Apply online: www.8cap.org**
Fax: 616-754-9310 **Email: deniseb@8cap.org** **Phone: 866-754-9315 ext. 3369**

State & Federally funded programs will not discriminate against anyone because of race, color, national origin, sex, age or disability.

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