FIVE COUNTY CHILD DEVELOPMENT PROGRAM, INC PRENTISS, MISSISSIPPI

This institution is an Equal Opportunity Provider

**Head Start Application**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CHILD’S INFORMATION** | | | | | | | | | | | | | | | | |
| CHILD’S LEGAL NAME (FIRST) (LAST) | | | | | | | | | | | | | | | | |
| PREFERRED NAME | | | | | | | | | BIRTHDAY | | | | GENDER:  ( ) MALE ( ) FEMALE | | | |
| RACE: ( ) ASIAN ( ) AFRICAN AMERICAN ( ) CAUCASIAN  ( ) AMERICAN INDIAN ( )HAWAIIAN PACIFIC ISLANDER  ( ) MULTI-RACIAL ( ) OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | HISPANIC  ( ) YES  ( ) NO | | | | PRIMARY LANGUAGE \_\_\_ENG\_\_\_ SP\_\_\_ OTHER\_\_\_\_\_  SECONDARY \_\_ENG\_\_\_SPANISH\_\_\_OTHER\_\_\_\_\_\_\_\_  NATIONAL ORIGIN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ETHNICITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| CHIP # | | | | | | | | | MEDICAID # | | | | | | | |
| TRICARE # | | | | | | | | | OTHER | | | | | | | |
| PRIVATE INSURANCE # | | | | | | | | | OTHER # | | | | | | | |
| PHYSICIAN  NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  PHONE #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | DENTIST  NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  PHONE #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| **Does your child have seizures, asthma, diabetes or any other chronic medical conditions? ( ) Yes ( ) No**  **Does your child have a diagnosed food allergy? ( ) Yes ( ) No \* If yes, to either question**  **Your child’s application will not be considered complete until we have all documentation from a doctor.** | | | | | | | | | | | | | | | | |
| OPTIONAL: CHILD HAS A DISABILITY or SPECIAL NEED ( ) YES ( ) NO ( ) SUSPECTED **(IF YES, DIAGNOSIS, DATE & SOURCES)** | | | | | | | | | | | | | | | | |
| WAS CHILD REFERRED TO PROGRAM ( ) YES ( ) NO (IF YES, BY WHOM & WHY) | | | | | | | | | | | | | | | | |
| **FAMILY INFORMATION** | | | | | | | | | | | | | | | | |
| PHYSICAL ADDRESS | | | | | | | | MAILING ADDRESS (IF DIFFERENT) | | | | | | | | |
| CITY STATE ZIP COUNTY | | | | | | | | CITY STATE ZIP | | | | | | | | |
| DIRECTIONS TO HOME | | | | | | | | | | | | | | | | |
| **Phone (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Type: ( ) Home ( )Work ( ) Cell ( )Message** | | | | | | | | **Phone (\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_**  **TYPE: ( ) HOME ( )WORK ( )CELL ( ) MESSAGE** | | | | | | | | |
| **May We Text You ( ) Yes ( ) No Email Address:** | | | | | | | | | | | | | | | | |
| **PROGRAM INFORMATION** | | | | | | | | | | | | | | | | |
| PROGRAM YEAR | PROGRAM CODE  HS | | PROGRAM DESC  PS | | | | DELEGATE ID  000 | | | | CLASS AGE | | | CENTER NAME | | |
| **ADULT FAMILY MEMBERS INFORMATION** | | | | | | | | | | | | | | | | |
| (A01) PRIMARY ADULT NAME (FIRST) (LAST)  **(Proof of income must be provided)** | | | | | | | | | | | | | | | | |
| DATE OF BIRTH | | GENDER  ( ) MALE  ( ) FEMALE | | | | | | EDUCATION LEVEL | | | | EMPLOYMENT STATUS | | OCCUPATION | | |
| |  |  | | --- | --- | | RACE: ( )ASIAN ( )AFRICAN AMERICAN ( ) CAUCASIAN ( ) AMERICAN INDIAN ( )HAWAIIAN PACIFIC ISLANDER ( ) MULTI-RACIAL ( ) OTHER\_\_\_\_\_\_\_\_\_\_ | HISPANIC  ( ) YES ( ) NO |   (A02) SECONDARY ADULT IN HOME (FIRST) (LAST)  **(Proof of income must be provided)** | | | | | | | | | | | | | | | | |
| DATE OF BIRTH | | GENDER  ( ) MALE  ( ) FEMALE | | | | | | EDUCATION LEVEL | | | | EMPLOYMENT STATUS | | OCCUPATION | | |
| RACE: ( )ASIAN ( )AFRICAN AMERICAN ( ) CAUCASIAN ( ) AMERICAN INDIAN ( )HAWAIIAN PACIFIC ISLANDER ( ) MULTI-RACIAL ( ) OTHER\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | HISPANIC  ( ) YES ( ) NO | | |
| **PARENTAL STATUS** | | | | | | | | | | | | | | | | |
| ( )SINGLE ( ) MARRIED ( ) SEPARATED ( ) DIVORCED ( ) FOSTER ( ) NON-PARENT ( ) OTHER | | | | | | | | | | | | | | | | |
| **CHILDREN** | | | | | | | | | | | | | | | | |
| FIRST & LAST  CHILDREN’S NAMES | | | | | DATE OF BIRTH | | | | | GENDER  M F | | | RELATED TO  A01=PRIMARY A02=SECONDARY B12=Both Adults  O=Other | HOW RELATED  C= CHILD F=FOSTER  G =GRANDCHILD  O=OTHER | | NOTES  A=APPLIED  O= OLD  Y=YOUNG |
| C01 PROGRAM APPLICANT | | | | | ---------- | | | | | --------- | | |  |  | | A |
| C02 | | | | |  | | | | |  | | |  |  | |  |
| C03 | | | | |  | | | | |  | | |  |  | |  |
| C04 | | | | |  | | | | |  | | |  |  | |  |
| C05 | | | | |  | | | | |  | | |  |  | |  |
| C06 | | | | |  | | | | |  | | |  |  | |  |
| DO YOU RECEIVE: SNAP ( )YES ( )NO WIC ( )YES ( )NO | | | | | | | | | | | | | | | | |
| TANF ( )YES ( )NO SSI ( )YES ( )NO MILITARY BENEFITS ( )YES ( )NO | | | | | | | | | | | | | | | | |
| **RELEASE CHILD TO & OR EMERGENCY CONTACT INFORMATION** | | | | | | | | | | | | | | | | |
| FIRST & LAST NAME | | | | RELATIONSHIP | | ADDRESS    PHONE # | | | | | | | | RELEASE  ( ) YES ( ) NO | EMERGENCY  ( ) YES ( )NO | |
| PHONE # | | | | | | | |
| FIRST & LAST NAME | | | | RELATIONSHIP | | ADDRESS  PHONE # | | | | | | | | RELEASE  ( ) YES ( ) NO | EMERGENCY  ( ) YES ( )NO | |
| PHONE # | | | | | | | |
| FIRST & LAST NAME | | | | RELATIONSHIP | | ADDRESS  PHONE # | | | | | | | | RELEASE  ( ) YES ( ) NO | EMERGENCY  ( ) YES ( )NO | |
| PHONE # | | | | | | | |
| OPTIONAL: ANY SPECIFIC FAMILY NEEDS OR CRISIS ( ) NO ( ) YES **(IF YES PLEASE DESCRIBE)** | | | | | | | | | | | | | | | | |
| TYPE OF INTERVIEW: ( ) IN PERSON ( ) PHONE ( ) OTHER **(IF NOT IN PERSON EXPLAIN)** | | | | | | | | | | | | | | | | |
| **CERTIFICATION: I CERTIFY THAT THIS INFORMATION IS TRUE. IF ANY PART IS FALSE, MY PARTICIPATION IN THIS AGENCY’S PROGRAMS MAY BE TERMINATED AND I MAY BE SUBJECT TO LEGAL ACTION. I ALSO UNDERSTAND THAT THE INFORMATION IN THIS APPLICATION WILL BE HELD IN STRICT CONFIDENCE WITHIN THE AGENCY AND IS ACCESSIBLE TO ME DURING NORMAL BUSINESS HOURS.** | | | | | | | | | | | | | | | | |
| **I GIVE FIVE COUNTY CHILD DEVELOPMENT PROGRAM PERMISSION TO VERIFY MY INCOME FROM A THIRD PARTY. ( ) YES ( ) NO**  **AGENCY TO BE CONTACTED (If Applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **CONFIRMED BY (Name, Title, Affiliation/Relationship)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **I give Five County permission to contact me by phone, text, or email. ( ) Yes ( )No** | | | | | | | | | | | | | | | | |
| PARENT/ GUARDIAN SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |
| VERIFYING STAFF SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |

NON-DISCRIMINATION POLICY: Five County does not discriminate based on race, color, national origin, religion, sex, gender, sexual orientation, disability, or age.

FIVE COUNTY HEAD START

Is Currently Accepting Applications for Head Start Children

This Institution is an Equal Opportunity Provider

Five County Child Development Program, Inc. is accepting applications for

Head Start children ages three and four for the upcoming program year 2021-2022.

Parents and/or guardians are required to provide the following information:

1. The child’s proof of birth date
2. The child’s immunization (up-to date shot) record on a 121 form
3. The child’s Medicaid or insurance information
4. Proof of residency
5. The family’s proof of income for the previous 12 months

(Examples: 2021 check stub and 2020 W-2 or Letters from Social Security for 2020 & 2021 or TANF benefits statements for the previous 12 months, 1040 income tax form, a self-declaration of income with verifying sources, letters from employers, foster care payments or documentation from public assistance.

1. A statement or Healthcare plan from a doctor if your child has a food allergy

or a chronic medical condition such as asthma or diabetes (if applicable)

1. A current Individualized Education Plan IEP/ IFSP if the child has a diagnosed disability, (if applicable)

*PLEASE HAVE DOCUMENTS WHEN APPLYING*

**Head Start services are provided at no cost to families that qualify**

Children who are experiencing Homelessness, Foster Care, Disabled will be given first priority for Head Start. All other children who are four or three-years old will be considered.

**Please call your local Head Start Center for more information or**

Janet Moak - Family Service/ ERSEA Director @ 601-792-5194 -fax # 601-792-8140

Jonathan Bines-Executive Director @ 601-792-5191

**NON-DISCRIMINATION POLICY: Five County does not discriminate based on race,**

**color, national origin, religion, sex, gender, sexual orientation, disability, or age.**