

PART 3 (CONT.) – CHILD APPLYING FOR 1ST YEAR

Does child have any chronic health problems: Yes ___ No ___ If yes, please explain

Does child receive ongoing services for any of these conditions? Yes ___ No ___

If yes, identify provider:

Child has completed preschool screening ___ Yes ___ No If yes, where _____

Please check the area(s) in which your child is receiving services or you have concerns:

- Autism Developmental Delay Emotional/Behavior Delay Health Impaired
- Hearing Impaired/Deafness Learning Disabilities Mental Retardation Multiple Disabilities
- Orthopedic Impaired Speech/Language Impaired Traumatic Brain Injury
- Visual Impaired/Blindness

Has your child been referred to or evaluated by a Local School District/ECSE or Health Professional?

___ Yes ___ No If yes, what was the concern? _____

Identify the School District or Health Professional _____

Does Child have an Individual Education Plan (IEP) Yes ___ No ___

Does Child have an Individual Family Service Plan (IFSP) Yes ___ No ___

DOCUMENTATION OF A DISABILITY/IEP/IFSP MUST BE ATTACHED

PART 4 CHILD APPLYING FOR 1ST YEAR OR OVER INCOME CHILD APPLYING FOR 2ND YEAR

Family Meets Special Considerations:

- Homeless Foster Care 1 Parent Household Teen Parent Incarcerated Parent Parent Loss by Death
- 1 Parent Household Unemployed Both Parents Unemployed 1 Parent Household has no High School Diploma/GED
- Neither Parent has High School Diploma/GED Language Support Needed
- Child resides with someone other than biological parent(s) Friend ___ Relative ___
- Public School/Community Agency/Health Professional Referral Current or History of Domestic Violence
- Parent has documented disability or mental health diagnosis Returning Over Income Child

Does child receive WIC? ___ Yes ___ No

PART 5 – CHILD APPLYING FOR 1ST YEAR OR OVER INCOME CHILD APPLYING FOR 2ND YEAR

My signature affirms:

- the information provided is accurate and true. Semcac Head Start may verify all information with regard to the age of my child and my family income.
- My Data Privacy Rights were reviewed with me.
- I give permission for Head Start to obtain my child’s preschool screening records. Yes ___ No ___

Parent/Guardian Signature _____ Date _____

I have reviewed the above application and verified the Family’s Income.

Staff Signature _____ Date _____

OFFICE ONLY

Family Meets Criteria for Head Start Act Sec. 645 [42 U.S.C. 9840] (a) (2) (A-D) Yes ___ No ___

- Town of residence has 1000 or fewer residents No other preschool in the community
- Resides in designated medically underserved area. (All H/F – Portions of D/M/W)