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: ______________________ *First* *MI* *Last* ________ *Date of Birth* ☐ Father ☐ Mother ☐ ________ *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: ________

Does your family recieve Supplemental Food Assistance (SNAP)? ☐ Yes ☐ No

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 ☐ SSD	☐ DHHS Financial ☐ Other:
Parent 2	$	☐ Weekly ☐ Monthly	☐ Bi-weekly ☐ Annually	☐ Working ☐ SSI	☐ Child Support ☐ SSD	☐ DHHS Financial ☐ Other:

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

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

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: 616-754-9315, option 2**

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

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