

HEAD START ENROLLMENT APPLICATION

School Year: _____

Age Verified: _____

PROGRAM SELECTION

Head Start Only:	<input type="checkbox"/> Fond du Lac	<input type="checkbox"/> North Fond du Lac	<input type="checkbox"/> Prairie View	<input type="checkbox"/> Ripon
Head Start/4k Collaboration:	<input type="checkbox"/> Fond du Lac	<input type="checkbox"/> North Fond du Lac		
Staff conducted interview:	<input type="checkbox"/> In-person	<input type="checkbox"/> Phone		
Staff Signature:				Date:
How did you hear about ADVOCAP's Head Start Program?				

PRIMARY PARENT/GUARDIAN

First Name:	Middle Initial:	Last Name:	
Birthdate:	Sex:	Relationship with child:	
Legal Guardian is:	<input type="checkbox"/> Biological Parent	<input type="checkbox"/> Foster Parent	<input type="checkbox"/> Court Ordered
Primary Parent/Guardian is in Jail/Prison:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Contact Information

Cell Phone:	Work Phone:
Consent to receive texts: <input type="checkbox"/> Yes <input type="checkbox"/> No	Email:

Race/Ethnicity

Race:	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American	
	<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Biracial/Multi-Racial	<input type="checkbox"/> Other
Ethnicity:	<input type="checkbox"/> Hispanic or Latino origin	<input type="checkbox"/> Non-Hispanic or Latino origin		

Education

<input type="checkbox"/> 0 - 8	<input type="checkbox"/> 9 – 12/Non-Grad	<input type="checkbox"/> High School Grad	<input type="checkbox"/> GED/HSED
<input type="checkbox"/> 12 Grade + Some College	<input type="checkbox"/> 2-year – voc. or tech. grad	<input type="checkbox"/> Advanced/4-year degree	

Work Status

Military Status:	<input type="checkbox"/> Veteran	<input type="checkbox"/> Active	<input type="checkbox"/> N/A	Disability Status:	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Work Status:	<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time	<input type="checkbox"/> Self Employed			
	<input type="checkbox"/> Unemployed (> 6 mos)	<input type="checkbox"/> Unemployed (≤ 6 mos)	<input type="checkbox"/> Unemployed (Not in Labor Force)			
	<input type="checkbox"/> Seasonal/Migrant	<input type="checkbox"/> Job Training or In School	<input type="checkbox"/> Retired			

Disconnected Youth

Not working or not in school (for 14-24 age group)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Health Insurance

<input type="checkbox"/> None	<input type="checkbox"/> Direct-Purchase	<input type="checkbox"/> Military	<input type="checkbox"/> Medicare
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Employment	<input type="checkbox"/> Other	

Language

<input type="checkbox"/> Primary Language:	<input type="checkbox"/> Secondary Language:
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HOUSEHOLD INFORMATION

Physical Address:	City:	
State:	Zip	County of Residence:
If Homeless:	<input type="checkbox"/> Certification of Homelessness	<input type="checkbox"/> Self-Certified

Family Type:

<input type="checkbox"/> Single Parent/Female	<input type="checkbox"/> Single Parent/Male	<input type="checkbox"/> Two-Parent Household
<input type="checkbox"/> Multi-Generational	<input type="checkbox"/> Extended Family	<input type="checkbox"/> Non-related Adults w/Children
<input type="checkbox"/> Other:	Number in Household:	Number in Family:

Housing Type:

<input type="checkbox"/> Rent	<input type="checkbox"/> Own	<input type="checkbox"/> Homeless
<input type="checkbox"/> Temporary Quarters	<input type="checkbox"/> Other	

HEAD START CHILD APPLICANT

First Name:	Middle Initial:	Last Name:
Birthdate:	Sex:	Relationship to HOH:

Race/Ethnicity

Race:	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American	
	<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Biracial/Multi-Racial	<input type="checkbox"/> Other
Ethnicity:	<input type="checkbox"/> Hispanic or Latino origin	<input type="checkbox"/> Non-Hispanic or Latino origin		

Health Insurance

<input type="checkbox"/> None	<input type="checkbox"/> Direct-Purchase	<input type="checkbox"/> Military
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Employment	<input type="checkbox"/> Other additional coverage: <input type="checkbox"/> Health <input type="checkbox"/> Vision <input type="checkbox"/> Dental

Language

Primary Language:	Secondary Language:
Child speaks English at home: <input type="checkbox"/> Yes <input type="checkbox"/> No	
English speaking skills: <input type="checkbox"/> Very well <input type="checkbox"/> Well <input type="checkbox"/> Not well <input type="checkbox"/> Not at all	

Services Received

<input type="checkbox"/> Speech/Language Therapy	<input type="checkbox"/> Birth to Three	<input type="checkbox"/> Early Childhood	<input type="checkbox"/> Counseling
Name of Counselor (if applicable):			

SECONDARY PARENT/GUARDIAN

First Name:	Middle Initial:	Last Name:
Birthdate:	Sex:	Relationship with child:
Secondary Parent/Guardian is: <input type="checkbox"/> Biological Parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Court Ordered		
Secondary Parent/Guardian is in Jail/Prison: <input type="checkbox"/> Yes <input type="checkbox"/> No		

Contact Information

Cell Phone:	Work Phone:
Consent to receive texts: <input type="checkbox"/> Yes <input type="checkbox"/> No	Email:

HOUSEHOLD INFORMATION

Physical Address:	City:
State: Zip	County of Residence:
If Homeless: <input type="checkbox"/> Certification of Homelessness <input type="checkbox"/> Self-Certified	

Family Type:

<input type="checkbox"/> Single Parent/Female	<input type="checkbox"/> Single Parent/Male	<input type="checkbox"/> Two-Parent Household
<input type="checkbox"/> Multi-Generational	<input type="checkbox"/> Extended Family	<input type="checkbox"/> Non-related Adults w/Children
<input type="checkbox"/> Other:	Number in Household:	Number in Family:

Housing Type:

<input type="checkbox"/> Rent	<input type="checkbox"/> Own	<input type="checkbox"/> Homeless
<input type="checkbox"/> Temporary Quarters	<input type="checkbox"/> Other	

Race/Ethnicity

Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American
<input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Biracial/Multi-Racial <input type="checkbox"/> Other
Ethnicity: <input type="checkbox"/> Hispanic or Latino origin <input type="checkbox"/> Non-Hispanic or Latino origin

Education

<input type="checkbox"/> 0 - 8	<input type="checkbox"/> 9 – 12/Non-Grad	<input type="checkbox"/> High School Grad	<input type="checkbox"/> GED/HSED
<input type="checkbox"/> 12 Grade + Some College	<input type="checkbox"/> 2-year – voc. or tech. grad	<input type="checkbox"/> Advanced/4-year degree	

Work Status

Military Status:	<input type="checkbox"/> N/A <input type="checkbox"/> Active	<input type="checkbox"/> Veteran	Disability Status:	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Work Status:	<input type="checkbox"/> Full-time <input type="checkbox"/> Unemployed (> 6 mos) <input type="checkbox"/> Seasonal/Migrant	<input type="checkbox"/> Part-time <input type="checkbox"/> Unemployed (≤ 6 mos) <input type="checkbox"/> Job Training or In School	<input type="checkbox"/> Self Employed <input type="checkbox"/> Unemployed (Not in Labor Force) <input type="checkbox"/> Retired		

Disconnected Youth

Not working or not in school (for 14-24 age group)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unspecified
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Health Insurance

<input type="checkbox"/> None	<input type="checkbox"/> Direct-Purchase	<input type="checkbox"/> Military	<input type="checkbox"/> Medicare
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Employment	<input type="checkbox"/> Other:	

Language

<input type="checkbox"/> Primary Language:	<input type="checkbox"/> Secondary Language:
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OTHER HOUSEHOLD MEMBERS (*CHILDREN* under 18)

First Name:	Middle Initial:	Last Name:	
Birthdate:	Sex:	Relationship to HOH:	Disability Status: <input type="checkbox"/> Yes <input type="checkbox"/> No

Race/Ethnicity

Race:	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American
	<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Biracial/Multi-Racial <input type="checkbox"/> Other
Ethnicity:	<input type="checkbox"/> Hispanic or Latino origin <input type="checkbox"/> Non-Hispanic or Latino origin		

Education

<input type="checkbox"/> 0 - 8	<input type="checkbox"/> 9 – 12/Non Grad	<input type="checkbox"/> High School Grad	<input type="checkbox"/> GED/HSED
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Disconnected Youth

Not working or not in school (for 14-24 age group)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Health Insurance

<input type="checkbox"/> None	<input type="checkbox"/> Direct-Purchase	<input type="checkbox"/> Military			
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Employment	<input type="checkbox"/> Other Additional Coverage:	<input type="checkbox"/> Health	<input type="checkbox"/> Vision	<input type="checkbox"/> Dental

Language

<input type="checkbox"/> Primary Language:	<input type="checkbox"/> Secondary Language:
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OTHER HOUSEHOLD MEMBERS (*ADULTS* 18 or over)

First Name:	Middle Initial:	Last Name:
Birthdate:	Sex:	Relationship to HOH:
Phone number:		

Race/Ethnicity

Race:	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American	
	<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Biracial/Multi-Racial	<input type="checkbox"/> Other
Ethnicity:	<input type="checkbox"/> Hispanic or Latino origin	<input type="checkbox"/> Non-Hispanic or Latino origin		

Education

<input type="checkbox"/> 0 - 8	<input type="checkbox"/> 9 – 12/Non-Grad	<input type="checkbox"/> High School Grad	<input type="checkbox"/> GED/HSED
<input type="checkbox"/> 12 Grade + Some College	<input type="checkbox"/> 2 or 4 year College Grad	<input type="checkbox"/> Grad of another post-secondary (Vocational/Tech)	

Work Status

Military Status:	<input type="checkbox"/> N/A	<input type="checkbox"/> Veteran	Disability Status:	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	<input type="checkbox"/> Active				

Work Status:	<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time	<input type="checkbox"/> Self Employed
	<input type="checkbox"/> Unemployed (> 6 mos)	<input type="checkbox"/> Unemployed (≤6 mos)	<input type="checkbox"/> Unemployed
	<input type="checkbox"/> Seasonal/Migrant	<input type="checkbox"/> Job Training or In School	<input type="checkbox"/> Retired

Disconnected Youth

Not working or not in school (for 14-24 age group)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Health Insurance

<input type="checkbox"/> None	<input type="checkbox"/> Direct-Purchase	<input type="checkbox"/> Military	<input type="checkbox"/> Medicare
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Employment	<input type="checkbox"/> Other	

Language

<input type="checkbox"/> Primary Language:	<input type="checkbox"/> Secondary Language:
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OTHER HOUSEHOLD MEMBERS (*CHILDREN* under 18)

First Name:	Middle Initial:	Last Name:	
Birthdate:	Sex:	Relationship to HOH:	Disability Status: <input type="checkbox"/> Yes <input type="checkbox"/> No

Race/Ethnicity

Race:	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American
	<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Biracial/Multi-Racial <input type="checkbox"/> Other
Ethnicity:	<input type="checkbox"/> Hispanic or Latino origin	<input type="checkbox"/> Non-Hispanic or Latino origin	

Disconnected Youth

Not working or not in school (for 14-24 age group)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Health Insurance

<input type="checkbox"/> None	<input type="checkbox"/> Direct-Purchase	<input type="checkbox"/> Military	<input type="checkbox"/> Medicare
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Employment	<input type="checkbox"/> Other Additional Coverage: <input type="checkbox"/> Health <input type="checkbox"/> Vision <input type="checkbox"/> Dental	

Language

<input type="checkbox"/> Primary Language:	<input type="checkbox"/> Secondary Language:
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OTHER HOUSEHOLD MEMBERS (*CHILDREN* under 18)

First Name:	Middle Initial:	Last Name:	
Birthdate:	Sex:	Relationship to HOH:	Disability status: <input type="checkbox"/> Yes <input type="checkbox"/> No

Race/Ethnicity

Race:	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American
	<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Biracial/Multi-Racial <input type="checkbox"/> Other
Ethnicity:	<input type="checkbox"/> Hispanic or Latino origin	<input type="checkbox"/> Non-Hispanic or Latino origin	

Disconnected Youth

Not working or not in school (for 14-24 age group)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Health Insurance

<input type="checkbox"/> None	<input type="checkbox"/> Direct-Purchase	<input type="checkbox"/> Military	<input type="checkbox"/> Medicare
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Employment	<input type="checkbox"/> Other Additional Coverage: <input type="checkbox"/> Health <input type="checkbox"/> Vision <input type="checkbox"/> Dental	

Language

<input type="checkbox"/> Primary Language:	<input type="checkbox"/> Secondary Language:
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