

United Indians Birth to Five Head Start
Daybreak Star Indian Cultural Center
Discovery Park, PO Box 99100
Seattle, WA 98199
(206) 285-4425 FAX (206) 282-3640

Office Use Only	
APPROVED	
NOT APPROVED	
<input type="checkbox"/> New	<input type="checkbox"/> Returning
<input type="checkbox"/> Over Income	
FSC/ECS Name: _____	

ENROLLMENT APPLICATION

Child Information

Child's Name: _____ Date of Birth: ____/____/____
Last First Middle

Preferred Name: _____ Child's Social Security #: _____ Gender: M F

Ethnic Origin:

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Native American | <input type="checkbox"/> Alaskan Native | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Latino |
| <i>Tribe:</i> _____ | <input type="checkbox"/> Asian | <input type="checkbox"/> Pacific Islander | <input type="checkbox"/> African |
| | <input type="checkbox"/> African American | <input type="checkbox"/> East Indian | <input type="checkbox"/> Other: _____ |

Child Resides With:

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Mother only | <input type="checkbox"/> Foster Parent(s) | <input type="checkbox"/> Mother & Stepfather |
| <input type="checkbox"/> Father only | <input type="checkbox"/> Grandparents | <input type="checkbox"/> Father & Stepmother |
| <input type="checkbox"/> Both Parents | <input type="checkbox"/> Other Relatives | <input type="checkbox"/> Other: _____ |

Family Information

Family Last Name: _____ Parental Language: _____

Parent/Guardian Name: _____ Social Security #: _____

Parent/Guardian Name: _____ Social Security #: _____

Address _____

City, State, Zip Code _____ County: _____

Home Phone: () _____ Work Phone: () _____ Other Phone: () _____

Primary language used in home: _____ Second Language: _____

of Persons: In Family: _____ In Home: _____ **# of Children:** In Family: _____ Ages 0-3: _____ Ages 4-5: _____

If pregnant, when is your due date? _____

Was child referred to program? Yes No If yes, by whom? _____

(Optional) Does child have a disability or special needs? Yes No Suspected Not Sure
If yes, or suspected, what is the concern? _____

Does child have an IEP/IFSP? Yes No If yes, by whom? _____

(Optional) Does family have any specific needs or crisis? Yes No
If yes, please describe: _____

Family Member Information

Adults

First and Last Name	Date of Birth	Social Security #	Gender	Education Level	Employment Status
			M F		
			M F		
			M F		

Children

First and Last Name	Date of Birth	Social Security #	Gender	Age	How Related
			M F		
			M F		
			M F		
			M F		
			M F		
			M F		

Eligibility Information

Has a child in family been enrolled in this program before? Yes No If yes, when? _____

Is child eligible next year? Yes No Is sibling eligible next year? Yes No

Do you know a family that you can refer to our program? Yes No

Would you be able to transport your child to the nearest Head Start bus stop if your home is located outside of the designated transportation area? Yes No

TANF (AFDC): Yes No Case Number: _____

Income (List by family member)			
1.	INCOME: \$	Income Received: <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	
2.	INCOME: \$	Income Received: <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	
3.	INCOME: \$	Income Received: <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	

Shaded Area To Be Completed By Verifying Staff Member

CACFP Status: Free Reduced Over Income **CACFP Household Income:** _____ **Certification date:** _____

Income Status: Eligible Over Income **Income Verified?** Yes No **By:** _____

Income Tax Return W-2 Form Social Security (SSI) DSHS Memo Letter

Child Support Check Stub Unemployment Benefits Pension/Retirement Other: _____

Child's Date of Birth Verified? Yes No **By:** _____

Certified Birth Certificate Hospital Birth Certificate Health Department Certificate Other: _____

Certification: *I certify that the information in this application is true and accurate. I also understand that the information in this application will be held in strict confidence within the program and is accessible to me during normal business hours.*

Parent/Legal Guardian Signature

Date

