CONTACTS: DS ______ / ______ (Date/Initials)
CHILD ID# ______
FAM. ID# ______

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HEAD START COMMUNITY PROGRAM OF MORRIS COUNTY, INC.

EARLY HEAD START RECRUITMENT FORM

____ DOVER CENTER (18 months – 3 y/o
18 Thompson Ave.
Dover, NJ 07801
973- 989-9052 Fax: 973-328-3306

OFFICE USE ONLY:
SCREEN'G DATE: ______ / ______
CODE #: ______ / ______ --# ______
POINTS: ______ / ______ SP. NEEDS: ____
STARTING DATE : ______ / ______
WITHDRAW DATE: ______ / ______

____ HOME BASED (0 – 18 months old)

____ PREGNANT WOMEN

****

DOCUMENTS NEEDED WITH APPLICATION:

GENDER: ____ M ____ F

____ IMMUNIZATION RECORD (CHILD)

____ CHILD'S PROOF OF AGE (Birth Certificate, Crib Card, Passport)

____ PROOF OF INCOME (Pay Stub, Unemployment Stub, W-2 Forms, Social Security Benefits, TANF Notice of Action with monthly amount)

PLEASE COMPLETE BOTH SIDES OF THIS FORM:

APPLIC. DATE: ______

How did you hear about Early Head Start? ______

Pregnant Woman's / Child's name: ______ Child's D.O.B. ______

Pregancy Due date ______

Home complete address: ______
(number, street, town, state, zip code)

Home phone #: ______ Language spoken at home: ______

Child: Mother's//Guardian's name: ______ Cel.Tel. #: ______

Address, if different from child's: ______ E-mail: ______

Place of employment/school: ______ Tel. #: ______

Work/School address: ______

Child: Father's//Guardian's name: ______ Cel .Tel. #: ______

Address (if different from child's) ______ E-mail: ______

Place of employment/school: ______ Tel. #: ______

Work/School Address: ______

INCOME INFORMATION: (Check those that apply):

____ Employment ____ Veteran's Benefits ____ Child Support/Alimony ____ Disability

____ S.S.I. ____ Unemployment Comp. ____ Public Assistance (TANF) ____ Workmen's Comp.

Other ______

No Income: Needs to complete "No Income Interview Form".

Household gross income (before taxes or deductions): $____________ per week / 2 weeks / month / year

LIST EVERY PERSON RESIDING IN YOUR HOME WHO IS SUPPORTED BY THE HOUSEHOLD INCOME (INCLUDING THE APPLICANT): **

Name:	D.O.B.	Relationship w/child:	School/Working?
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Is your child enrolled in any other Infant or Toddler Program? ____No ____ Yes, Which one? ____________________

Are you and/or your child receiving: SNAP____ WIC____

Health issues: ______________________________ Allergies: ____________________

Disability/Handicap diagnosis:____

Additional information that might help in working w/you /your child: ____________________________________

____

____

PLEASE INCLUDE ANY OTHER PHONE NUMBER WHERE YOU CAN BE REACHED AT:

Name: ____________________________ Phone #'s: ____________________; ____________________

Name: ____________________________ Phone #'s: ____________________; ____________________

Misrepresentation of information or falsification of documents may void eligibility for services. To the best of my knowledge, the above information is correct. I understand Head Start will be kept it conficential.

____

Signature / Child's Parent/Guardian Signature **Date**

ANY CHANGE OF INFORMATION CAN AFFECT THE QUALIFYING STATUS OF THE APPLICATION. PLEASE CONTACT THE MAIN OFFICE TO UPDATE YOUR APPLICATION.

**TO INCLUDE CHILD SUPPORT EXPENSES CHILD'S PARENT/GUARDIAN MUST SUBMIT CERTIFYING DOCUMENTATION.

____

Received by (Head Start staff) **Date**