CONTACTS:

DS: _____/_____

CHILD ID#_____

FAM. ID#_____

****

HEAD START COMMUNITY PROGRAM OF MORRIS COUNTY, INC.

RECRUITMENT FORM

___ DOVER CENTER (MAIN OFFICE)
18 THOMPSON AVE.
DOVER, NJ 07801
973- 989-9052 Fax: 973-328-3306

___MORRISTOWN CENTER
540 W. HANOVER AVE.
MORRIS TWP, NJ 07950
973- 889-8818 Fax: 973-889-1353

OFFICE USE ONLY:
SCREEN'G DATE:_____/_____

CODE #: _____/_____--#_____

POINTS: _____/_____ SP. NEEDS: ____

STARTING DATE : _____

WITHDRAW DATE: _____

****

DOCUMENTS NEEDED WITH APPLICATION:

___ IMMUNIZATION RECORD (UPDATED)

___ 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)

SESSIONS:
8:00 – 11:30 AM ____
12:30 – 4:00 PM ____
8:00 AM – 3:00 FD ____

GENDER: ____M ____F

PLEASE COMPLETE BOTH SIDES OF THIS FORM:

APPLIC. DATE: _____

How did you hear about Head Start? _____

Child's name: _____ D.O.B. _____

Home phone #: _____ Language spoken at home: _____

Mother's/Stepmother's/Guardian's name: _____ Cel.Tel. #:_____

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

Place of employment: _____ Tel. #: _____

Work address: _____ E-mail: _____

Father's/Stepfather's/Guardian's name: _____ Cel .Tel. #:_____

Address (if different from child's)_____

Place of employment: _____ Tel. #: _____

Address: _____ E-mail: _____

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.

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

___NO INCOME: Family needs to complete the "No Income Interview Form".

VERIFIED BY: (OFFICE USE ONLY)

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.			

Are you and/or your child receiving: ____Food Stamps ____WIC ____Medicaid/NJ FamilyCare: # _____?

Child's health issues: _____ Allergies: _____

Disability/Handicap diagnosis: _____

Additional information that might help in working w/your child: Ex. Shyness, no friends to play with, late in talking, wets, etc.

_____

_____

PLEASE INCLUDE ANY OTHER PHONE NUMBER WHERE YOU CAN BE CONTACTED:

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.

_____ _____

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.

_____ _____

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