



Applicant & Family Member Information

Pregnant Woman						
First	Middle	Last	Birthday	Gender	SSN	
Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little	<input type="checkbox"/> Yes, (please list)	<input type="checkbox"/> Little	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate	_____	<input type="checkbox"/> Moderate	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None	<input type="checkbox"/> No	<input type="checkbox"/> None	
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient		<input type="checkbox"/> Proficient	
Primary Health Coverage	Other Coverage	Insurance #	Medicaid Eligibility	Medicaid #	Doctor/Medical Home	
			<input type="checkbox"/> Not Eligible			
			<input type="checkbox"/> On Medicaid			
			<input type="checkbox"/> Potentially			
Dental Coverage	Dental Coverage #		Dentist/Dental Home			

Secondary/Other Adult (Baby's Father)					
First	Middle	Last	Birthday	Gender	
Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little	<input type="checkbox"/> Yes, (please list)	<input type="checkbox"/> Little
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate	_____	<input type="checkbox"/> Moderate
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None	<input type="checkbox"/> No	<input type="checkbox"/> None
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient		<input type="checkbox"/> Proficient
Highest Grade Completed	Employment Status	Child's Relationship	Custody	Check all that apply:	
<input type="checkbox"/> No High School or GED	<input type="checkbox"/> Full Time	<input type="checkbox"/> Biological /Adopted	<input type="checkbox"/> Yes	<input type="checkbox"/> Lives with Family	
<input type="checkbox"/> High School or GED	<input type="checkbox"/> Part Time	<input type="checkbox"/> /Step	<input type="checkbox"/> No	<input type="checkbox"/> Provides Financial Support	
<input type="checkbox"/> Associate Degree, Vocational School or Some College	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Grandchild		<input type="checkbox"/> Teen Parent	
<input type="checkbox"/> Bachelor or Advance Degree	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Other Relative			
	<input type="checkbox"/> Retired	<input type="checkbox"/> Foster			
	<input type="checkbox"/> Disabled	<input type="checkbox"/> Other			
Email Address:					

Family Information				
Family Living Address				
Living Address	ZIP	City	State	County
Family Mailing Address				
Same as living?	Mailing Address	ZIP	City	State
<input type="checkbox"/> Yes <input type="checkbox"/> No				
Phone Number(s)	Type (check one)	Note (extension or best time to call)	Opt In for Text Messages	
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other		<input type="checkbox"/> Yes <input type="checkbox"/> No	



Additional Family Information (Please answer all questions)			
Parental Status: <input type="checkbox"/> One <input type="checkbox"/> Two	Referred by a Child Welfare Agency? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Pregnant Woman Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Incarcerated Spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is your Family Homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No	Receiving SNAP? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you seen a doctor for your Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Head Start Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No
Active Duty Military? <input type="checkbox"/> Yes <input type="checkbox"/> No	Receiving WIC? <input type="checkbox"/> Yes, WIC ID _____ <input type="checkbox"/> No	Are you employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have support from family or Community Resources? <input type="checkbox"/> Yes <input type="checkbox"/> No
# of Months Pregnant: _____	Pregnant Teen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Food Security? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this a high-risk pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you pregnant with twins, triplets or other multiples? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is there chemical dependency issues in the family? <input type="checkbox"/> Yes <input type="checkbox"/> No	Displaced by Natural Disaster? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Family Income		
What was your family's total YEARLY income for 2020? Please add income from all sources (salary, child support, unemployment, etc.) that your family received and enter the number below in U.S. Dollars. Yearly Income: \$ _____	# of Persons in Family: _____	TANF Status <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Formerly on TANF/Not now
		SSI <input type="checkbox"/> Yes <input type="checkbox"/> No

Emergency Contacts				
Contact 1	Name	Relationship	Emergency Contact	Release To
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Address	ZIP	City	State
	Phone Number 1	Phone Number 2		
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	
Contact 2	Name	Relationship	Emergency Contact	Release To
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Address	ZIP	City	State
	Phone Number 1	Phone Number 2		
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	

Additional Children					
First	Middle	Last	Birthday	Gender	
Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency	
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USDA Nondiscrimination Statement

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This institution is an equal opportunity provider.

How did you hear about our program?
<input type="checkbox"/> Word of Mouth <input type="checkbox"/> Social Media <input type="checkbox"/> Community Referral <input type="checkbox"/> Website <input type="checkbox"/> Other _____

Verification: I certify that the information provided in this application, and the income indicated for enrollment eligibility, is accurate and truthful to the best of my knowledge. Providing false income/information could result in dismissal from the program and may be subjected to legal action. I also understand that the information given to the program will remain confidential and is accessible to me during normal business hours.

Pregnant Woman Signature	Date	Head Start Staff Signature	Date