☐ Early Head Start
☐ Childcare Network

Early Head Start/Childcare Network

If you have questions concerning completion of this application, contact your local Head Start Center or Central Office.

CSRA EOA, Inc. Early Head Start

1261 Greene Street
P.O. Box 10104
Augusta, Georgia 30903-2704
706-722-0493

PLEASE DO NOT WRITE IN THIS BOX

RECRUITMENT APPLICATION

ChildPlus ID# _____

Child's Legal Name: Last First M.I

2. Date of Birth | 3. Child's Social Security Number | 4. Race

5. Is child a relative of any Head Start staff? ____Yes _____ No
If Yes, give name(s), relationship, and department:_____

6. Sex: Male or Female

7. Child lives with ____M=Mom ____D=Dad ____F=Foster Parent ____L=Legal Guardian (please provide verification)

8. Address City State Zip Code County

9. Telephone Number: Home: (____) _____ Cell: (____) _____

Message: (____) _____ Email:_____

10. Mother's Name (lives with Child ____Yes ____No)
Education Level: _____
Social Security Number:_____
Marital Status: Married Single Divorced Separated Widowed

11. Street Address
Mailing Address

12. City State Zip County

13. Telephone Number: Home_____
Message_____

14. Father's Name (lives with Child ____Yes ____No)
Education Level: _____
Social Security Number:_____
Marital Status: Married Single Divorced Separated Widowed

15. Address
Mailing Address

16. City State Zip County

17. Telephone Number: Home_____
Email Address: _____
Message_____

18. Legal Guardian (lives with Child ____Yes ____No)
Education Level: _____
Social Security Number:_____
Relationship to Child:_____
Marital Status: Married Single Divorced Separated Widowed

19. Street Address
Mailing Address

20. City State Zip County

21. Telephone Number: Home_____
Email Address: _____
Message_____

22. Is your child currently attending a child development center? ___ Yes ____ No

Name of Day Care:_____ Phone Number:_____

Address:

23. Are you on TANF? Yes____ No____ TANF No:_____
Previous TANF participant Yes____ No____
Are you on WIC? Yes____ No____ WIC No:_____
Are you on SSI? Yes____ No____
Is your child on SSI? Yes____ No____ Child's Name:_____
Is your child on SNAP? Yes____ No____
Are you in the Military Yes____ No____
Are you on CAPS? Yes____ No____
Are you CAPS eligible? Yes____ No____

24. Was child referred to the Program? ____Yes _____No What agency?_____

By Whom? _____

25. Child's Medicaid/Private Insurance Provider's Name_____

Number:_____

26. Language spoken at home_____

Language spoken by Child_____

27. Any specific family need or crisis? ____Yes ____No

Are you homeless? (optional) ___Yes ___No

28. Does your family/child have a medical home? ___Yes ___No

Does your family/child have a dental home? ___Yes ___No

29. Health Issues: Asthma___ Allergy/Food Allergy____ Seizures_____ Heart Problems _____ Sickle Cell_____ Other____
(Doctor's verification required)

30. Does child have a suspected disability? ___Yes ___No

Doctor's Name_____

Diagnosis_____

31. Does your child have a diagnosed disability with an IFSP? ___Yes __No

32. Give the number of persons: in Family _____ Number of Children_____ Number of children 6 years old or younger_____

Family Member Income

Adults	Annual Income	Source of Income	Education Level	Employment Status

Family Member Information

Children

Name	Relationship to Child	Sex	Date of Birth	Social Security Number

In order for this application to be processed the following information must be attached:

1. **Certified Birth Certificate**
2. **Verification of income** (W-2 form, copy of Tax Return, TANF/DFCS Summary notification, SSI, Security Benefits Letter, Dept. of Labor Four Quarter Print out, child Support)
3. **Immunization Certificate** (3231 Form)

CERTIFICATION: I certify that this information is true. If any part is false, my participation in this agency's program may be terminated and I may be subjected to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.
I understand that I will be responsible to transport my child to and from the center. Once your child is accepted and enrolled, your child will remain eligible for the Early Head Start program until the age of three years old.

Parent/Legal Guardian Signature_____ Date_____

Signature of Verifying Staff Member_____ Date_____