



# Early Head Start & Head Start Program Enrollment Application

Renewal Unlimited, Inc.  
 2900 Red Fox Run  
 Portage, WI 53901  
 Phone: 608/742-5329 or  
 800/344-7543  
 Fax: 608/742-5481

The information collected on this application is necessary for our records and will be kept confidential.

Child Information						
First	Middle	Last	Suffix	Nickname	Birth Date	Gender
					___/___/___	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Verification of Child's Birth Date*:</b> <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Crib Card <input type="checkbox"/> WIR <input type="checkbox"/> Well Child Check <input type="checkbox"/> Immigration Papers		<b>Race</b> <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Native American/Alaska Native <input type="checkbox"/> Bi-racial/Multi-racial	<input type="checkbox"/> Black/African-American <input type="checkbox"/> Other Please Specify "Other": _____		<b>Hispanic</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Primary Language</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Native Central American, South American, & Mexican <input type="checkbox"/> Caribbean <input type="checkbox"/> Middle Eastern & South Asian <input type="checkbox"/> East Asian			<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Pacific Island <input type="checkbox"/> European & Slavic <input type="checkbox"/> African <input type="checkbox"/> Other: _____		<b>English Proficiency</b> <input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient	<b>Other Language</b> <b>Proficiency</b> <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient
<b>Child's Primary Health Insurance</b>		<b>Medicaid Eligibility</b> <input type="checkbox"/> Not Eligible <input type="checkbox"/> On Medicaid <input type="checkbox"/> Not Sure	<b>Doctor/Clinic</b>	<b>Child's Dental Insurance</b>		<b>Dentist/Clinic</b>
<b>Disability Status of Child</b> <input type="checkbox"/> None <input type="checkbox"/> Suspected <input type="checkbox"/> Certified IEP** <input type="checkbox"/> Certified IFSP** Explanation of Special Needs(s): _____ **** Attach copy of IEP/IFSP to the application or parent/guardian must sign Release Request for child's school district so Head Start staff can acquire the IEP/IFSP. Attach signed Release Request to the application.						
Child Care Provider Information						
Name	Phone Number	Cell Phone	Home Address	City/State	Zip Code	
Parent/Guardian Information						
First	Middle	Last	Suffix	Nickname	Birth Date	Gender
					___/___/___	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Home Address</b>		<b>City/State</b>	<b>Zip Code</b>	<b>County</b>	<b>Phone Number</b>	<b>Cell Number</b>
<b>Mailing Address if Different Than Above</b>				<b>City/State</b>	<b>Zip Code</b>	<b>County</b>
					<b>Resides with Child</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Race</b> <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Native American/Alaska Native <input type="checkbox"/> Bi-racial/Multi-racial		<input type="checkbox"/> Black/African-American <input type="checkbox"/> Other Please Specify "Other": _____	<b>Hispanic</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>English Proficiency</b> <input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient	<b>Other Language</b> <b>Proficiency</b> <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient	<b>Pregnancy</b> <input type="checkbox"/> Yes Due Date ___/___/___ <input type="checkbox"/> No <b>Current High Risk Pregnancy</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Highest Grade Completed</b> <input type="checkbox"/> Associate's <input type="checkbox"/> Bachelor's <input type="checkbox"/> Tech College/Trng <input type="checkbox"/> Some College/Trng <input type="checkbox"/> Master's		<input type="checkbox"/> < Grade 9 <input type="checkbox"/> Grade 10 <input type="checkbox"/> Grade 11 <input type="checkbox"/> Grade 12 <input type="checkbox"/> HS Graduate <input type="checkbox"/> GED	<b>Employment Status</b> <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Unemployed	<input type="checkbox"/> Full Time & Training <input type="checkbox"/> Part Time & Training <input type="checkbox"/> Training or School <input type="checkbox"/> Retired <input type="checkbox"/> Disabled	<b>Child's Relationship</b> <input type="checkbox"/> Biological/Adopted/Step <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Relative <input type="checkbox"/> Foster <input type="checkbox"/> Other	<b>Parental Status</b> <input type="checkbox"/> Single Parent <input type="checkbox"/> Two Parent Household <b>Court Papers</b> <input type="checkbox"/> Custody Papers in Place <input type="checkbox"/> Restraining Order in Place
<b>Email Address:</b> _____			I am a veteran of the United States Military. <input type="checkbox"/> Yes <input type="checkbox"/> No			

### Official Use Only:

Center/Site _____	Program Year 20 ____-20 ____	DOE ___/___/___	Eligibility Point Total _____
Total Income \$ _____	Income Guideline \$ _____	CE _____ IE _____ OI _____ SNS _____ SND _____	# of Yrs in Program _____
Homeless _____	Foster Care _____	SSI _____	Public Assistance/TANF: W-2 _____ CCS _____
Office Staff Signature for Eligibility Verification _____		0-3 EHS _____	3-5 HS _____ FF _____
		Date _____/_____/_____	

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_

Secondary Parent/Guardian Information											
First	Middle	Last	Suffix	Nickname	Birth Date	Gender					
					___/___/___	<input type="checkbox"/> Male <input type="checkbox"/> Female					
Home Address		City/State	Zip Code	County	Phone Number	Cell Number					
Mailing Address if Different Than Above		City/State	Zip Code	County	Resides with Child						
					<input type="checkbox"/> Yes <input type="checkbox"/> No						
Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency						
<input type="checkbox"/> Asian <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Native American/Alaska Native <input type="checkbox"/> Bi-racial/Multi-racial		<input type="checkbox"/> Black/African-American <input type="checkbox"/> Other Please Specify "Other": _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		<input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient					
Highest Grade Completed		Employment Status		Child's Relationship							
<input type="checkbox"/> Associate's <input type="checkbox"/> Bachelor's <input type="checkbox"/> Tech College/Trng <input type="checkbox"/> Some College/Trng <input type="checkbox"/> Master's		<input type="checkbox"/> < Grade 9 <input type="checkbox"/> Grade 10 <input type="checkbox"/> Grade 11 <input type="checkbox"/> Grade 12 <input type="checkbox"/> HS Graduate <input type="checkbox"/> GED		<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Unemployed		<input type="checkbox"/> Full Time & Training <input type="checkbox"/> Part Time & Training <input type="checkbox"/> Training or School <input type="checkbox"/> Retired <input type="checkbox"/> Disabled			<input type="checkbox"/> Biological/Adopted/Step <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Relative <input type="checkbox"/> Foster <input type="checkbox"/> Other		
Email Address: _____				I am a veteran of the United States Military. <input type="checkbox"/> Yes <input type="checkbox"/> No							
Other Children/Adults Living In The Household *											
First	Middle	Last	Gender	Date of Birth	Relationship to Child						
			<input type="checkbox"/> Male <input type="checkbox"/> Female	___/___/___							
			<input type="checkbox"/> Male <input type="checkbox"/> Female	___/___/___							
			<input type="checkbox"/> Male <input type="checkbox"/> Female	___/___/___							
			<input type="checkbox"/> Male <input type="checkbox"/> Female	___/___/___							
			<input type="checkbox"/> Male <input type="checkbox"/> Female	___/___/___							
			<input type="checkbox"/> Male <input type="checkbox"/> Female	___/___/___							
			<input type="checkbox"/> Male <input type="checkbox"/> Female	___/___/___							
Additional Eligibility Information (Check all that apply)											
<input type="checkbox"/> Grandparent/Relative as Guardian <input type="checkbox"/> Teen Parent (age 17 or less) <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Parent/Guardian Disabled <input type="checkbox"/> Parent/Guardian Incarcerated <input type="checkbox"/> Parent/Guardian Deployed Military <input type="checkbox"/> High Risk Pregnancy/Multiple Unborns (Pregnant Mothers Only)		<input type="checkbox"/> Parent/Guardian without High School Diploma, HSED, GED <input type="checkbox"/> No Transportation <input type="checkbox"/> Death of Immediate Family Member with Past 24 months <input type="checkbox"/> Receiving W-2 (TANF)* <input type="checkbox"/> Receiving Child Care Subsidies (TANF)* <input type="checkbox"/> Receiving SSI*		<input type="checkbox"/> Parent/Guardian with Substance/Alcohol Abuse Concerns <input type="checkbox"/> Enrolled Child Moved within Our Service Area <input type="checkbox"/> Child/Parent/Guardian with Mental Health Concerns <input type="checkbox"/> Child Currently Enrolled in the Family Foundations Program/Nurse Family Partnership Program							
Child Protective Services											
<input type="checkbox"/> Not Applicable <input type="checkbox"/> Court Ordered Participation in Head Start* <input type="checkbox"/> Foster Parent*		<input type="checkbox"/> Referred by Welfare Agency List Referring County _____									
Housing Status of Primary Parent/Guardian											
<input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Homeless*	If homeless, please describe your current housing status: <input type="checkbox"/> Sharing housing with others <input type="checkbox"/> Living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative accommodations <input type="checkbox"/> Abandoned in hospitals <input type="checkbox"/> Primary night-time residence is a public or private place not designed for/ordinarily used as a regular sleeping accommodation for human beings <input type="checkbox"/> Living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings <input type="checkbox"/> Migratory children who are living in circumstances described above <input type="checkbox"/> Living in emergency/transitional <input type="checkbox"/> Waiting foster care placement										

\*\* Indicates that Head Start Staff make all reasonable efforts to verify status.

## Income Verification

### Total Family Members in Household

Total immediate family members in household: Number of Adults \_\_\_\_\_ Number of Children \_\_\_\_\_  
 (Family counts include the child listed on this application and all persons in the child's primary household who are supported by the income of the parent/guardian of the child AND related to the parent/guardian by blood, marriage, adoption OR the child's authorized caregiver/legal responsible party)

The Administration for Children and Families requires that we have written income verification for families of Head Start children.

### Income Verification:

Documentation/Item(s) Seen By Staff	Income Source*	Gross Income or Net Income for Self-Employed including Farming (List in appropriate column below)				Number of weeks or months income was Received in past 12 months (must be recorded)	
		Weekly	Bi-Weekly	Monthly	Yearly	# of Weeks	# of Months
	Employment						
	Employment						
	Company/Government Pensions						
	Self-Employment						
	Bank Interest						
	Unemployment Compensation						
	Worker's Compensation						
	Social Security						
	Supplemental Security Income (SSI)						
	Child Support/Alimony						
	Other Income: Source of Income:						
	Source of Other Income:						

Complete the following if "No Income": Time period of no income: From \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_ Explain family circumstances and efforts made to verify income:

### Consent for 3<sup>rd</sup> Party Verification of Information

I give my permission for Renewal Unlimited, Inc. – Head Start to verify the information listed above with any necessary sources and/or other agencies.  
 Not applicable  No  Yes If "Yes", please provide name(s), titles(s), affiliation(s), and phone numbers(s) of the people we may contact.

Summary of statement made by 3<sup>rd</sup> Party:

### Additional Contacts

Name	Phone Number	Cell Number
Name	Phone Number	Cell Number

### Application Completed

In-person  Phone Interview Explain the reason why the application was completed through phone interview: \_\_\_\_\_

### Signatures

I hereby state that the information that I provided is truthful and correct. I also understand that completing this application does not guarantee my child will be enrolled in the program.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby state that I have made reasonable efforts to verify that the information stated above is correct and truthful.

Head Start Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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