



Monterey County Office of Education Head Start & Early Head Start Program



Services provided to pregnant women and children 0-5 years old including children with disabilities.

APPLY TO HEAD START/EARLY HEAD START NOW!

If you need assistance or have any questions regarding this application, please call **(831)784-4172** and/or **(831)755-0350** and/or toll free **(888)973-2800**

1. Required documents to determine eligibility: Applications cannot be processed without:

- Proof of **ALL** household **income** for **past 12 months** (Previous year 1040 forms, W2s, check stubs, TANF (cash aid)/Passport to Services report, unemployment, child support, and disability pay stubs.)
- Child's most recent **immunization** record *
- Child's **birth certificate** *
- Child's **Medical card** * (if applicable)
- Pre-enrollment Critical **Health History form** * (attached)
- Residency Questionnaire** (attached)

**Items with (*) are not applicable for pregnant women.*

2. Mail to:

MCOE Head Start/Early Head Start or Submit to your nearest Head Start Center
P.O. Box 80851 (see brochure for sites)
Salinas, CA 93912

3. We will contact you after we process your application to inform you of the eligibility status.

Note: Transportation is NOT provided by Monterey County Office of Education Head Start/EHS.

* HS/EHS will consider over income children with a diagnosed disability and other over income opportunities.

** Enrollment will be selected based on the criteria point system.



Monterey County Office of Education Head Start & Early Head Start Program



Enrollment Application

Application is required for EACH child.

ID#: _____

Child/Applicant Last Name:		First Name:		Date of Birth:	Country of Birth:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Are you a pregnant mother? <input type="checkbox"/> Yes <input type="checkbox"/> No		Race: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Other:		Ethnicity: Hispanic or Latino <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Language:	
Parent/Guardian #1:			Date of Birth:	Do they live in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Education Grade Level: <input type="checkbox"/> 0 through 9 th <input type="checkbox"/> 10 th <input type="checkbox"/> 11 th <input type="checkbox"/> 12 th <input type="checkbox"/> High School Diploma <input type="checkbox"/> GED <input type="checkbox"/> Some College <input type="checkbox"/> Vocational School/Training <input type="checkbox"/> AA Degree <input type="checkbox"/> Bachelors Degree <input type="checkbox"/> Masters Degree				Employment Status: <i>(check all that apply)</i> <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Homemaker <input type="checkbox"/> Seasonal /Temporary <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired/Disabled <input type="checkbox"/> Part Time & Training/School <input type="checkbox"/> Full Time & Training/School			
Primary Language:				Occupation:			
Parent/Guardian #2:			Date of Birth:	Do they live in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Education Grade Level: <input type="checkbox"/> 0 through 9 th <input type="checkbox"/> 10 th <input type="checkbox"/> 11 th <input type="checkbox"/> 12 th <input type="checkbox"/> High School Diploma <input type="checkbox"/> GED <input type="checkbox"/> Some College <input type="checkbox"/> Vocational School/Training <input type="checkbox"/> AA Degree <input type="checkbox"/> Bachelors Degree <input type="checkbox"/> Masters Degree				Employment Status: <i>(check all that apply)</i> <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Homemaker <input type="checkbox"/> Seasonal /Temporary <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired/Disabled <input type="checkbox"/> Part Time & Training/School <input type="checkbox"/> Full Time & Training/School			
Primary Language:				Occupation:			
Living Address:			City:	State:	Zip Code:		
Mailing Address <i>(if different)</i> P.O. BOX:			City:	State:	Zip Code:		
Cell Number:		Text Messages? <input type="checkbox"/> Yes <input type="checkbox"/> No		Home Number:		Message Number:	
Child lives with: <input type="checkbox"/> Two Parents <input type="checkbox"/> Single Parent <input type="checkbox"/> Foster Parent(s) <input type="checkbox"/> Grandparents <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other/Relative: _____							
How many family members are living in the home and are supported by the income reported? <u>You must list all others below.</u>							
Other Family Member		Date of Birth		Other Family Member		Date of Birth	
Are you receiving TANF/CalWORKs (cash aid)? <input type="checkbox"/> Yes <input type="checkbox"/> No				Do you have a court issued custody agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you receive child support? <input type="checkbox"/> Yes <input type="checkbox"/> No				Do you have family employed by MCOE Head Start/EHS? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Received unemployment benefits within the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No				Is either parent incarcerated? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Did you file your taxes last year? <input type="checkbox"/> Yes <input type="checkbox"/> No				Do you have access to childcare? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is anyone in your family receiving SSI? (Supplemental Security Income) <input type="checkbox"/> Yes <input type="checkbox"/> No				Were you referred by a child welfare agency? (CPS/Foster Care/Adoption/Shelter, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is your family receiving Supplemental Nutrition Assistance? (SNAP/CalFresh/Food Stamps) <input type="checkbox"/> Yes <input type="checkbox"/> No				Is at least one parent/guardian a member of the United States military on active duty <input type="checkbox"/> Yes <input type="checkbox"/> No or a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Type of insurance: <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Emergency Medi-Cal <input type="checkbox"/> Private				Does your insurance include dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
I give permission for Head Start/EHS staff to have third party conversations with any person who is able to validate my family's circumstances in order to verify eligibility. <i>Staff must adhere to program privacy policies and procedures.</i> <input type="checkbox"/> Yes <input type="checkbox"/> No Parent Initials _____							
Is there anything else you want us to consider for eligibility? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____							
Preferred center? 1 st _____ 2 nd _____ <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Extended Day (not offered at all sites)							
<i>I certify that the statements in this application, any legal documents and the income provided are true and complete. If any part is false, my participation in Head Start may be terminated. I understand that this information is being given in connection with the receipt of federal funds. I release from liability persons or organizations reporting information required by this application. I understand that deliberate misrepresentation of information may subject me to prosecution under state and federal regulations.</i>							
Parent/Guardian Signature _____				Date _____			
Staff Signature _____				Date _____			



Monterey County Office of Education Head Start & Early Head Start Program



CHILD HEALTH QUESTIONNAIRE

Child's Name: _____ **Date of birth:** ____/____/____
(last) (first) (mi)

<p>1. Does your child have breathing problems or asthma? a. Has your child ever used any of the following medications? <input type="checkbox"/> Inhaler <input type="checkbox"/> Nebulizer i. For what medical condition? _____ ii. When did your child last use it? ____/____/____ (date)</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>2. Has your child ever had seizures or convulsions? a. Does your child take medications for this condition? b. What is the cause of the seizures/convulsions? _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>3. Is your child allergic to any foods? a. Name of the food(s) allergic to and describe your child's allergic reaction: Foods: _____ Allergic reaction(s) _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>4. Does your child have any feeding or eating problems that require dietary changes or special equipment? a. Describe eating/feeding problem(s): _____ b. What are the special dietary changes or equipment needed: _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>5. Is your child allergic to any medications? a. Name of medication(s): _____ b. Describe allergic reaction(s): _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>6. Has your child ever had major surgery or been hospitalized? a. Date of surgery/hospitalization: ____/____/____ b. Reason: _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>7. Does your child have a diagnosed disability? a. Type of disability: _____ b. Does your child have a current IEP (Individualized Educational Plan) or IFSP (Individualized Family Service Plan)? If so, attach most recent copy.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>8. Do you have any concerns about your child's: a. Speech? If yes, describe: _____ b. Hearing? If yes, describe: _____ c. Vision? If yes, describe: _____ d. Dental health? If yes, describe: _____ e. Allergies? If yes, describe: _____ f. Developmental delays? If yes, describe: _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>9. Does your child have any other health conditions or developmental concerns? a. Condition or concern: _____ b. Is your child under medical care for this condition/concern? c. Does your child take medications for this condition/concern? 1. Name of medication: _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>10. Please provide us with additional information or comments that will help us understand your child's current health status or concerns: _____ _____ _____</p>	

I authorize _____ at _____
(name of health provider) (health provider address) (provider phone)

to share my child's health information with MCOE's Head Start/EHS program. This information will be used to accommodate my child's medical needs while in the Head Start Program. Head Start/EHS will maintain all health information confidential.

Parent/Guardian: _____ / _____ / _____
(parent signature) (parent name) (date)



Monterey County Office of Education Head Start & Early Head Start Program



901 Blanco Circle Post Office Box 80851 Salinas, California 93912-0851
Phone (831) 755-0350 Fax (831) 755-6480

Residency Questionnaire/ McKinney –Vento Act U.S.C 11435

Applicant/Child’s Name: _____, _____ DOB: ____/____/____
(Last) (First)

Parent’s Name: _____, _____
(Last) (First)

Your answers will help determine documents necessary for enrollment of this applicant/child.

1. Do you share housing due to economic reasons? () YES () NO
2. Is your current address a temporary living arrangement? () YES () NO
 - a) Is this due to loss of housing or economic hardship? () YES () NO

3. Presently where is the applicant/child living? *Indicate with a (√)*

	in a shelter
	with more than one family in a house or apartment
	in a motel
	moving from place to place
	in a place not designed for ordinary sleeping accommodations such as a car, park, or campsite
	Other <i>(please specify)</i> :

I give/ do not give permission for Head Start/EHS staff to have third party conversations with any person who is able to validate my family’s circumstances in order to verify eligibility. *Staff must adhere to program privacy policies and procedures.*

I certify that the statements are true and complete. I release from liability persons or organizations reporting information required by this application. I understand that deliberate misrepresentation of information may subject me to prosecution under State and Federal regulations under section 37.10 Penal Code.

Parent/Guardian’s Signature _____

Date _____

Verified by Staff Person _____

Date _____