



**Grand Forks Head Start
3600 6th Avenue North
Grand Forks, ND 58203**



ENROLLMENT CHECKLIST/WHAT TO BRING:

<input type="checkbox"/>	Completed application (each page filled out)
<input type="checkbox"/>	Signature on last page
<input type="checkbox"/>	Documents listed below:

<input type="checkbox"/>	Proof of Age (3-year olds must turn 3 on or before July 31st of current school year)	One of the below documents: <input type="checkbox"/> Certified Birth Certificate <input type="checkbox"/> Passport
<input type="checkbox"/>	Proof of Income (include all parents/guardians in the home for the past 12 months) <u>Must be dated within the previous 12 months</u>	One of the below documents: <input type="checkbox"/> Individual Income Tax Form 1040 (Preferred) <input type="checkbox"/> ALL W-2 Forms Copy of the following (if applicable): <input type="checkbox"/> Child Support (previous 12-month statement) <input type="checkbox"/> TANF <input type="checkbox"/> Work Study, Fellowship, Scholarship, or Grant <input type="checkbox"/> SSI/Social Security (letter from SS office) <input type="checkbox"/> Unemployment benefits <input type="checkbox"/> Statement of no income if unemployed and have none of the above (available @ HS office)
<input type="checkbox"/>	Medicaid Number (if applicable)	
<input type="checkbox"/>	Immunization Record	

***APPLICATIONS WITHOUT INCOME VERIFICATION WILL NOT BE PROCESSED**

Grand Forks Head Start classes run Monday through Thursday, 8:00 am-3:30 pm.

Please note: No transportation provided.

→ If you have questions or need help with the application or documents, please call 701-746-2433 and ask to speak with the enrollment team.

Fax: 701-746-2450

GRAND FORKS HEAD START ENROLLMENT APPLICATION

CHILD INFORMATION

Legal Name: First _____ Middle _____ Last _____

Date of Birth: ____/____/____ **Age by July 31st** 3 4 **Gender:** Male Female

Race:

- | | |
|---|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Biracial/Multiracial |
| <input type="checkbox"/> Asian | <input type="checkbox"/> White Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Pacific Islander | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Black/African American | |

Languages spoken at home: Put a **"P"** by the **PRIMARY** language used in the home and an **"S"** by the **SECONDARY** language used in the home (if any).

- | | |
|--|---|
| <input type="checkbox"/> African languages | <input type="checkbox"/> Middle Eastern and South Asian languages |
| <input type="checkbox"/> Caribbean languages | <input type="checkbox"/> Native Central or South American/Mexican languages |
| <input type="checkbox"/> East Asian languages | <input type="checkbox"/> Native North American/Alaska Native languages |
| <input type="checkbox"/> European and Slavic languages | <input type="checkbox"/> Pacific Island languages |
| <input type="checkbox"/> English | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Other (specify): _____ | |

Regardless of primary language, how well does your child speak English? Very well Well Not well Not at all

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1

Parent/Guardian #1 Name: _____ Male Female Other: _____

Date of Birth (MM/DD/YYYY): _____ Race: _____ Hispanic: Yes No

Residential address:

City: _____ State: _____ Zip Code: _____ Email: _____

Secondary mailing address:

Home phone: _____ Cell phone: _____ Work phone: _____

Active military? Yes No Military veteran? Yes No

Parent/Guardian #2

Parent/Guardian #2 Name: _____ Male Female Other: _____

Date of Birth (MM/DD/YYYY): _____ Race: _____ Hispanic: Yes No

Address: Check if all info is same as above

City: _____ State: _____ Zip Code: _____ Email: _____

Secondary mailing address:

Home phone: _____ Cell phone: _____ Work phone: _____

Active military? Yes No Military veteran? Yes No

Detailed Parental/Guardian Information

Detailed Parental/Guardian Information		
	<u>Parent/Guardian #1</u>	<u>Parent/Guardian #2</u>
Name:		
Live in home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Current marital status:	<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Separated	<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Separated
What language(s) do you speak?		
How well do you speak English?	<input type="checkbox"/> Very well <input type="checkbox"/> Well <input type="checkbox"/> Not well <input type="checkbox"/> None	<input type="checkbox"/> Very well <input type="checkbox"/> Well <input type="checkbox"/> Not well <input type="checkbox"/> None
Highest grade completed?	<input type="checkbox"/> Master's degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Associate's degree <input type="checkbox"/> College degree/Training certificate <input type="checkbox"/> General Education Development (GED) <input type="checkbox"/> High school graduate <input type="checkbox"/> Grade 11 <input type="checkbox"/> Grade 10 <input type="checkbox"/> Grade 9 or less	<input type="checkbox"/> Master's degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Associate's degree <input type="checkbox"/> College degree/Training certificate <input type="checkbox"/> General Education Development (GED) <input type="checkbox"/> High school graduate <input type="checkbox"/> Grade 11 <input type="checkbox"/> Grade 10 <input type="checkbox"/> Grade 9 or less
Relationship to enrolling child?	<input type="checkbox"/> Biological mother <input type="checkbox"/> Biological father <input type="checkbox"/> Stepparent <input type="checkbox"/> Adoptive parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Legal guardian <input type="checkbox"/> No biological/legal relationship <input type="checkbox"/> Other relative: _____	<input type="checkbox"/> Biological mother <input type="checkbox"/> Biological father <input type="checkbox"/> Stepparent <input type="checkbox"/> Adoptive parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Legal guardian <input type="checkbox"/> No biological/legal relationship <input type="checkbox"/> Other relative: _____
Are you in job training or school?	<input type="checkbox"/> Yes, full-time <input type="checkbox"/> No <input type="checkbox"/> Yes, part-time	<input type="checkbox"/> Yes, full-time <input type="checkbox"/> No <input type="checkbox"/> Yes, part-time
Mark all that apply:	<input type="checkbox"/> Work full time <input type="checkbox"/> Retired <input type="checkbox"/> Work part time <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Seeking employment	<input type="checkbox"/> Work full time <input type="checkbox"/> Retired <input type="checkbox"/> Work part time <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Seeking employment

OTHER MEMBERS OF THE HOUSEHOLD

1. How many people live in your household? _____	2. How many in your household are under 18 years old? _____			
Of everyone in your household, how many are financially supported by the listed parent(s)/guardian(s)? _____ (include parents in total)				
<u>Name</u>	<u>Date of birth</u>	<u>Gender</u>	<u>How well do they speak English?</u>	<u>Relationship to applying child</u>
1.	__/__/____	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	<input type="checkbox"/> Very Well <input type="checkbox"/> Well	<input type="checkbox"/> Not well <input type="checkbox"/> Not at all
2.	__/__/____	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	<input type="checkbox"/> Very Well <input type="checkbox"/> Well	<input type="checkbox"/> Not well <input type="checkbox"/> Not at all
3.	__/__/____	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	<input type="checkbox"/> Very Well <input type="checkbox"/> Well	<input type="checkbox"/> Not well <input type="checkbox"/> Not at all
4.	__/__/____	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	<input type="checkbox"/> Very Well <input type="checkbox"/> Well	<input type="checkbox"/> Not well <input type="checkbox"/> Not at all
5.	__/__/____	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	<input type="checkbox"/> Very Well <input type="checkbox"/> Well	<input type="checkbox"/> Not well <input type="checkbox"/> Not at all
6.	__/__/____	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	<input type="checkbox"/> Very Well <input type="checkbox"/> Well	<input type="checkbox"/> Not well <input type="checkbox"/> Not at all

FAMILY INFORMATION

Please be as honest as possible. This information will remain confidential and will only be used to determine family and child needs and/or placement priority.

Housing Information

Where does your family currently live?	<input type="checkbox"/> In a house or apartment (parent/guardian listed on mortgage or lease) <input type="checkbox"/> In a hotel/motel room <input type="checkbox"/> With friends or family <input type="checkbox"/> In a community shelter <input type="checkbox"/> Other living situation, please explain: _____
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Applying Child's Medical Information

Include evaluations for any diagnoses or conditions below

1. Has your child been diagnosed or seen by a specialist for health or developmental concerns?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosis: _____ Name of specialist or agency: _____
2. Does your child receive any type of therapy? (ex: speech/physical/occupational/behavioral therapy)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Include documentation with this application
3. Is your child on an Individual Education Plan? (IEP)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Include a copy of the IEP with this application
4. Does your child have a medical provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of doctor: _____
5. Does your child have a dental provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of dentist: _____
6. Does your child have health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Insurance provider name: _____
7. Does your child have Medical Assistance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medical assistance #: _____

OTHER FAMILY/SOCIAL FACTORS

1. Did any person or agency refer you to this program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who or what agency? _____
2. Has there been documented child abuse or neglect?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

CHILD CARE INFORMATION

1. Has the applying child been in Head Start before?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When/where? _____
2. Have the child's siblings been in Head Start before?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When/where? _____

TUBERCULOSIS HISTORY

1. Has a family member or contact had tuberculosis disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has a family member had a positive tuberculin skin test?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Was your child born in a high-risk country? (countries other than the US, Canada, New Zealand, or Western European countries)	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has your child visited a high-risk country for more than one week and had contact with its residents?	<input type="checkbox"/> Yes <input type="checkbox"/> No

FINANCIAL RESOURCES

Does your family receive any of the following? (check all that apply) **Provide documentation for each if applicable***

(If you have any questions about the type of Social Security you are receiving, please call the Social Security Office at 1-800-772-1213.)

<input type="checkbox"/> Child support/Alimony* <input type="checkbox"/> SNAP (Supplemental Nutrition Assistance Program) <input type="checkbox"/> Work study, a fellowship, scholarship, or grant* <input type="checkbox"/> Other source of income not listed above <input type="checkbox"/> WIC (Women, Infants, and Children)	<input type="checkbox"/> Supplemental Security Income (SSI)* <input type="checkbox"/> Supplemental Security Disability Income (SSDI)* <input type="checkbox"/> Unemployment benefits* <input type="checkbox"/> TANF (Temporary Assistance for Needy Families)*
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EMPLOYMENT HISTORY

Parent/Guardian #1

<u>Place of employment (list most current first)</u>	<u>Position</u>	<u>Currently employed here?</u>	<u>Work status</u>	<u>How are you paid?</u>	<u>Provide one of following documents</u>
1. Start date: _____ End date: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Self employed <input type="checkbox"/> Other: _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly	- 1040 tax form - ALL W-2(s)
2. Start date: _____ End date: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Self employed <input type="checkbox"/> Other: _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly	

Parent/Guardian #2

<u>Place of employment (list most current first)</u>	<u>Position</u>	<u>Currently employed here?</u>	<u>Work status</u>	<u>How often are you paid?</u>	<u>Provide one of following documents</u>
1. Start date: _____ End date: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Self employed <input type="checkbox"/> Other: _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly	- 1040 tax form - ALL W-2(s)
2. Start date: _____ End date: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Self employed <input type="checkbox"/> Other: _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly	

I affirm I am the parent or legal guardian of the child applying for Head Start, and to the best of my knowledge, all information I have provided is complete and correct. I understand if I deliberately misrepresent my family circumstances, my family may not be eligible for further services. I authorize Head Start to verify my family income and circumstances with the North Dakota Department of Human Services (DHS) and with my employer, if necessary.

X _____
Parent/Legal Guardian
Date

Applications are considered incomplete and will become VOID if income is not submitted within 90 days of receipt of application.

Intake/Interview date: _____ Staff signature: _____