The Delta Connection

DELTA Network Coordinated Application **Pg ONE – Eligibility**

STUDENT INFORMATION				
CHILD'S NAME				
	First Name	MI	Last Name # 1	Last Name # 2
DATE OF BIRTH	__ __/__ __/__ __ __ __	SSN	__ __ __ - __ __ - __ __ __ __	GENDER ☐ Male ☐ Female
AGE		PHONE NUMBERS	__ __ __- __ __ __- __ __ __ __ __ __ __- __ __ __- __ __ __ __	EMAIL
PHYSICAL ADDRESS	Street			
	City	State	Zip	
MAILING ADDRESS	Street			
	City	State	Zip	
PERSON CHILD RESIDES WITH	_____	RELATIONSHIP TO CHILD	_____	

Does child receive Special Education Services?(IEP)		Does child receive Speech Services? (IEP)	
YES	NO	YES	NO
Does child receive Early Intervention Services? (IFSP)		**Has child been referred by Psychological services?**	
YES	NO	YES	NO
Does child have a suspected disability?		**If YES, what is the disability?**	
YES	NO		

Do you work or go to school? _____Work _____ A Student _____Neither

FAMILY INCOME INFORMATION						
Number of Adults		Number of Adults Contributing to Income		Number of Children		☐ Approved for USDA/CACFP Eligibility Determination
Adult Name		Employer Name/Income Source		Time Period/ Income (wkly, monthly, bimonthly etc.)		
Income			Total Family			

The Delta Connection

DELTA Network Coordinated Application **Pg TWO – Application**

Ranking a program 1st or 2nd DOES NOT guarantee enrollment. Enrollment can be limited by factors including availability of seats and preferences for siblings/residential area.

CHILD'S NAME				
	First Name	MI	Last Name # 1	Last Name # 2

Please rank the programs below in order of preference. Put a "1" for your first choice,"2" for your second choice, and so on. Only rank programs for which you are eligible.

RANKING	PROGRAM	TYPE
	Delta Head Start/Early Head Start- Tallulah	Head Start
	Gultery Child Care Learning Center	Child Care
	Kids Planet Learning Center	Child Care
	Madison Parish School Board	Public School
	Tallulah Charter School	Public School

Child's Race: O African American O Caucasion O Hispanic O Other _____

If child has any siblings currently attending any program above, please list below:

Program	Siblings

If child has any siblings currently applying to any program above, please list below:

Program	Siblings

I, the undersigned, understand that sharing the information I have provided in this application across early childhood programs in my community will facilitate matching my child to a seat, and I hereby give permission for the information provided here to be shared with the programs in the Madison Community Network.

Print Name of Parent/Guardian: **Date of Birth:**

Parent/Guardian Signature **Date**

The Delta Connection

DELTA Network Coordinated Application **THREE – Head Start Supplement**

HEAD START SUPPLEMENT

THE FOLLOWING PAGES ARE ONLY REQUIRED IF HEAD START IS 1ST OR 2ND CHOICE.

Answer these questions ONLY if you are applying to Head Start.

TO BE COMPLETED BY HEAD START STAFF

*This application **MUST** include copies of the following:*

Birth Certificate	Yes ☐ No ☐	Medical Card	Yes ☐ No ☐
Social Security Card	Yes ☐ No ☐	Proof of Income	Yes ☐ No ☐
Up-To-Date Shot Record	Yes ☐ No ☐	Disability Diagnosis (if applicable)	Yes ☐ No ☐
School Schedule (EHS)	Yes ☐ No ☐	Infant/Pregnant Mom Paper work	Yes ☐ No ☐

*If the child is not living with his/her legal guardian, the adult **MUST** obtain a notarized Affidavit of Intent. This should also be attached to this application.*

*As per Delta Head Start's "Eligibility, Recruitment, Selection, Enrollment and Attendance Policy", this application **CANNOT** be placed on our waiting list until all of the above documentation has been received and attached.*

STAFF SIGNATURE: DATE:

For Office Use Only

- ☐ Application Completed (initial) _____ Application Number _____ Parental Status _____
- ☐ Criteria Points _____ ☐ ___Over-Income ___Income eligible
- ☐ If over-income approved, give reasons: _____

Site: ☐ Tallulah ☐ Delhi ☐ Rayville ☐ Mangham ☐ Lake Providence ☐ 1st Year ☐ 2nd Year ☐ 3rd Year

Application Date: _____

How did you hear about Head Start/EHS? _____ ☐ Agency Referral

Alternate Contact: _____ Phone: _____

Alternate Contact: _____ Phone: _____

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FAMILY INFORMATION

Please list below everyone living in your household beginning with the Head of Household

NAME	AGE	RELATIONSHIP TO CHILD	EMPLOYED (FT/PT)	IN SCHOOL (FT/PT)	EHS
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

ASSISTANCE INFORMATION

What other income and assistance is your family currently receiving?

- ☐ TANF
- ☐ Unemployment Insurance
- ☐ SSI – Disability/Survivors
- ☐ HUD
- ☐ Other _____
- ☐ Food Stamps
- ☐ WIC
- ☐ Medicaid/CHIP
- ☐ Child Support
- ☐ None of the above

Do you have a pre-existing plan with another local service provider? ☐ Yes ☐ No
Name of Agency: _____

Do you have any immediate emergency needs? ☐ Food ☐ Housing ☐ Utilities ☐ Clothing
☐ Health Care ☐ Other _____

Mothers: Are you currently pregnant or anyone in household? ☐ Yes ☐ No
If yes, are receiving pre-natal care? ☐ Yes ☐ No
How Many Months? _____

The Delta Connection

Teen Parent	**YES**	**NO**	**Homeless in the last year**	**YES**	**NO**
Marital Status	☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**		**Person's role in household**	☐ **Mother/Mother Figure** ☐ **Father/Father Figure** ☐ **Household member** ☐ **Resides outside the home**	
Family type	**__Two parent family** **__Foster family**		**One parent family __(mother figure only)** **__Other:_____**	**One parent family __(father figure only)**	
Primary Occupational Status (check only one)	**Paying Job:** __Full Time (more than 34 hrs per week) __Part Time __Seasonal – non- Agricultural __Seasonal - Agricultural __Employed and in school		**In School Full Time and Employed Part Time:** __Towards high school diploma/GED __Towards trade/business qualification __Towards college degree __Other __In school and employed	**Employed Full Time and In School Part Time** __Towards high school diploma/GED __Towards trade/business qualification __Towards college degree __Other __Employed and in school	
	Other: __In job training program __Homemaker __Unable to work due to disability __Retired __Unemployed		**Highest level of education (check only one)** __No school completed __Some K-12 school (no diploma) __High School graduate/GED __Some college (no degree)	__Associate degree __Bachelor's degree __Master's degree __Doctorate degree	
Was child referred to Head Start?			**If YES, by whom:**		
YES	**NO**		**Public School System**	**Community Agency**	**Other: _____**
Income Verification: Staff Only					
__ Individual Tax Form __ W-2 Form __Pay Stubs __ Written Employer Statement __ Public Assistance __ Unemployment __ Documentation of No Income					
__ Other:_____ Staff Signature:_____					

The Delta Connection

CHILD CARE INFORMATION

Who cares for your child when you are at work or school?

- ☐ Child Care Center, please specify: _____
- ☐ Child Care Home, please specify: _____
- ☐ Relative or other adult in your home
- ☐ Relative or other adult in their home
- ☐ Other: _____

How is the child care paid for?

- ☐ Self-Pay ☐ Subsidized
- ☐ Sliding Scale

Do you need child care year round? Yes, why? _____

No, why not? _____

Type of Housing

- ☐ Mobile Home
- ☐ House
- ☐ Apartment

Do you:

- ☐ Rent
- ☐ Own
- ☐ Other: _____

_____Length of time at current address

_____Number of times family has moved in past 12 months

TRANSPORTATION INFORMATION

☐ Yes ☐ No Do you need transportation? **(DHS does not provide transportation for EHS)**

☐ Yes ☐ No Do you have access to a working vehicle?

ADDITIONAL INFORMATION

Are any members of your household incarcerated? ☐ Yes ☐ No

Are any members of your household disabled? ☐ Yes ☐ No

Do any members of your family have a chronic health issue? ☐ Yes ☐ No

Would you like for your child's father or other significant male to participate with your child at Head Start/EHS? ☐ Yes ☐ No

If yes, Please state Father's Name or Significant Male Name: _____

CERTIFICATION: I certify that this information is true. If any part is false, my participation in the Delta Head Start/EHS program may be terminated. 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.

Incomplete applications will not be considered for enrollment and will be placed in a holding file until such date that copies of **ALL** required documentation is received.

PARENT SIGNATURE: _____ DATE: _____

STAFF VERIFICATION: _____ DATE: _____