



Allegany County Human Resources Development Commission, Inc.
 Head Start/Early Head Start
 125 Virginia Avenue
 Cumberland, MD 21502
 301-783-1730
 FAX#: 301-876-9081
 TTY/TDD 1-800-982-9877
 APPLY TODAY! ☺

Primary Adult Name: _____ **I am applying for: (check all that apply)**
 Head Start Child (3,4 &5 yrs) **Early Head Start(birth-2yrs)** **Early Head Start Pregnant Women**

Child Applicant Information

Last	First	MI	Preferred	Suffix
Birthdate	SSN	Gender		
	- -	Male Female		

Address/Phone

Living Address				Mailing Address (if different than living)		
Living Address Line 2				Mailing Address Line 2		
City	State	Zip	Co.	City	State	Zip
Phone Code: H- Home C- Cell M- Message P- Pager/Beeper W- Work				Note: Fill in Email for ALL individuals where applicable.		
Phone Code	Phone Number			✓ If Primary #	Enter email If wish to be contacted by Email.	
()	-				Email-	
()	-				2nd Email	

Child Applicant Health Coverage

Medicaid Eligibility Status: <input type="checkbox"/> On Medicaid <input type="checkbox"/> Not Eligible <input type="checkbox"/> Potentially Eligible		Medicaid Number
Primary Health Coverage	Other Health Coverage	Insurance Number
Name of Primary Physician		Name of Primary Dentist

Child Applicant Demographics

Race/Check all that Applies	Language	✓ if Primary	Proficiency	Proficiency Language Code
<input type="radio"/> Asian <input type="radio"/> Black <input type="radio"/> White <input type="radio"/> Native American <input type="radio"/> Pacific Islander <input type="radio"/> Other	English			0-None 1-Poor 2-Moderate 3-Proficient
Nationality			Ethnicity	

VERY IMPORTANT

You **MUST** send copies of the following items with this registration in order for it to be processed.

- 1) **PROOF OF INCOME** (all that are checked in the Income source box)
- 2) **CHILD'S SOCIAL SECURITY CARD**
- 3) **CHILD'S BIRTH CERTIFICATE**

You may send a copy of your Federal Income Tax form for the most recent tax year or three (3) consecutive pay stubs or unemployment pay stubs. For Public Assistance or other benefits, you must submit a copy of your award letter. For child support or alimony, you must submit a copy of the court order or copies of three (3) consecutive checks.

All children must be up to date on their shots, have a current physical and recent screening from the dentist.

Primary Adult Member Information

(Complete for each non-applicant family member)

<input type="checkbox"/> Primary Adult				
Last Name	First Name	Middle	Preferred	Suffix
Birthdate	SSN	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Lives with Family? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provides Financial Support <input type="checkbox"/> Yes <input type="checkbox"/> No		
Child's Relationship Code: C- Natural/Adopted/Step ; F- Foster ; G- Grandchild N- Niece/Nephew ; O- Other Relationship to Child? _____		Highest Grade Completed Code: <input type="checkbox"/> COL- College/Advance Training <input type="checkbox"/> G9-Grade 9 or less <input type="checkbox"/> CTG- College Degree /Training Certificate <input type="checkbox"/> G-10 <input type="checkbox"/> G-11 <input type="checkbox"/> G-12 <input type="checkbox"/> HSG-High School Grad <input type="checkbox"/> GED <input type="checkbox"/> A-Associate's Degree <input type="checkbox"/> B-Bachelor's Degree <input type="checkbox"/> M-Master's Degree		
Do you have custody? <input type="checkbox"/> Yes <input type="checkbox"/> No		Highest Grade Completed	Teen Parent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Present Employment Status Code: <input type="checkbox"/> F-Full Time (35hr.wk) <input type="checkbox"/> B-Full Time and Training <input type="checkbox"/> P-Part Time <input type="checkbox"/> L-Part Time and Training <input type="checkbox"/> R-Retired or Disabled <input type="checkbox"/> S- Seasonally Employed <input type="checkbox"/> T- Training or School <input type="checkbox"/> U- Unemployed		Present Employment Status:	Subsidized: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Primary Adult's Health Coverage

Medicaid Eligibility Status: <input type="checkbox"/> On Medicaid <input type="checkbox"/> Not Eligible <input type="checkbox"/> Potentially Eligible		Medicaid Number
Primary Health Coverage	Other Health Coverage	Insurance Number
Name of Primary Physician		Name of Primary Dentist

Primary Adult's Demographics

Race/Check all that Applies	Language	√ if Primary	Proficiency	Proficiency Language Code
<input type="radio"/> Asian <input type="radio"/> Black <input type="radio"/> White <input type="radio"/> Native American <input type="radio"/> Pacific Islander <input type="radio"/> Other	English			0-None 1-Poor 2-Moderate 3-Proficient
US Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No If no where?			Ethnicity	

Primary Adult's Employment

I am currently working, attending school or am in training	If currently working, how long have you been at your current job?	I have a severe health condition	Is transportation an on going problem for your family?
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes please specify where:	How Long _____ Where _____		If yes, why? _____

Secondary Adult Member Information

(Complete for each non-applicant family member)

<input type="checkbox"/> Secondary Adult				
Last Name	First Name	Middle	Preferred	Suffix
Birthday		SSN	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Lives with Family? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provides Financial Support <input type="checkbox"/> Yes <input type="checkbox"/> No		
Child's Relationship Code: C- Natural/Adopted/Step ; F- Foster ; G- Grandchild N- Niece/Nephew ; O- Other Relationship to Child? _____		Highest Grade Completed Code: <input type="checkbox"/> COL- College/Advance Training <input type="checkbox"/> G9-Grade 9 or less <input type="checkbox"/> CTG- College Degree /Training Certificate <input type="checkbox"/> G-10 <input type="checkbox"/> G-11 <input type="checkbox"/> G-12 <input type="checkbox"/> HSG <input type="checkbox"/> GED <input type="checkbox"/> A-Associate's Degree <input type="checkbox"/> B-Bachelor's Degree <input type="checkbox"/> M-Master's Degree		
Do you have custody? <input type="checkbox"/> Yes <input type="checkbox"/> No		Highest Grade Completed	Teen Parent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Present Employment Status Code: <input type="checkbox"/> F-Full Time (35hr.wk) <input type="checkbox"/> B-Full Time and Training <input type="checkbox"/> P-Part Time <input type="checkbox"/> L-Part Time and Training <input type="checkbox"/> R-Retired or Disabled <input type="checkbox"/> S- Seasonally Employed <input type="checkbox"/> T- Training or School <input type="checkbox"/> U- Unemployed		Present Employment Status:	Subsidized: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Secondary Adult's Health Coverage

Medicaid Eligibility Status: <input type="checkbox"/> On Medicaid <input type="checkbox"/> Not Eligible <input type="checkbox"/> Potentially Eligible		Medicaid Number
Primary Health Coverage	Other Health Coverage	Insurance Number
Name of Primary Physician		Name of Primary Dentist

Secondary Adult's Demographics

Race/Check all that Applies	Language	√ if Primary	Proficiency	Proficiency Language Code
<input type="radio"/> Asian <input type="radio"/> Black <input type="radio"/> White <input type="radio"/> Native American <input type="radio"/> Pacific Islander <input type="radio"/> Other	English			0-None 1-Poor 2-Moderate 3-Proficient
Nationality			Ethnicity	

Secondary Adult's Employment

I am currently working, attending school or am in training <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify where: _____	If currently working, how long have you been at your current job? How Long? _____ Where: _____	I have a severe health condition <input type="checkbox"/> Yes <input type="checkbox"/> No	Is transportation an on going problem for your family? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, why? _____	Notes: _____ Notes: _____
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Child Family Member #1
(Complete for each non-applicant family member)

Last	First	MI	Preferred	Suffix
Birthday	SSN	Gender Male Female		

Child's Health Coverage

Medicaid Eligibility Status: <input type="checkbox"/> On Medicaid <input type="checkbox"/> Not Eligible <input type="checkbox"/> Potentially Eligible		Medicaid Number
Primary Health Coverage	Other Health Coverage	Insurance Number
Name of Primary Physician		Name of Primary Dentist

Child's Demographics

Race/Check all that Applies	Language	√ if Primary	Proficiency	Proficiency Language Code
<input type="radio"/> Asian <input type="radio"/> Black <input type="radio"/> White <input type="radio"/> Native American <input type="radio"/> Pacific Islander <input type="radio"/> Other	English			0-None 1-Poor 2-Moderate 3-Proficient
Nationality			Ethnicity	

Child Family Member #2
Complete for each non-applicant family member

Last	First	MI	Preferred	Suffix
Birthday	SSN	Gender Male Female		

Child's Health Coverage

Medicaid Eligibility Status: <input type="checkbox"/> On Medicaid <input type="checkbox"/> Not Eligible <input type="checkbox"/> Potentially Eligible		Medicaid Number
Primary Health Coverage	Other Health Coverage	Insurance Number
Name of Primary Physician		Name of Primary Dentist

Child's Demographics

Race/Check all that Applies	Language	√ if Primary	Proficiency	Proficiency Language Code
<input type="radio"/> Asian <input type="radio"/> Black <input type="radio"/> White <input type="radio"/> Native American <input type="radio"/> Pacific Islander <input type="radio"/> Other	English			0-None 1-Poor 2-Moderate 3-Proficient
Nationality			Ethnicity	

In order for us to plan our program to meet the needs of our families, you could be very helpful by providing the information below. Indicate the option that best meets your needs. Unfortunately, we cannot guarantee that the times you mark will be available.

<input type="checkbox"/> Morning only from ____AM to ____PM Who takes care of your child after Head Start? _____
<input type="checkbox"/> Afternoon only from ____PM to ____PM Who takes care of your child in the morning? _____
<input type="checkbox"/> Morning and afternoon from ____AM to ____PM
<input type="checkbox"/> Evening from ____PM to ____PM Who takes care of your child during the summer? _____
Would you enroll your child for 9 months or 12 months? <input type="checkbox"/> 9 months <input type="checkbox"/> 12 months If not 12 months, who takes care of you child during the summer? _____
As an option to a classroom program, would you consider having a personalized learning program in your home? A Home Based teacher would visit your home once a week to be with you and your child and a socialization day would be scheduled twice a month for playgroup experience . <input type="checkbox"/> yes <input type="checkbox"/> no
If yes, when would you like your personalized program? <input type="checkbox"/> Weekdays <input type="checkbox"/> daytime or <input type="checkbox"/> evening after 5pm. <input type="checkbox"/> Saturdays <input type="checkbox"/> daytime or <input type="checkbox"/> evenings after 5pm.
How could the Head Start Program further assist you with your current childcare needs?
Please check all that apply: <input type="checkbox"/> Inform me about childcare in the community and how I can get the services I need. <input type="checkbox"/> Provide infant and toddler childcare at the Head Start center. <input type="checkbox"/> Provide before school care at the Head Start center for my school age children.
What areas would you be interested in obtaining information about? <input type="checkbox"/> Employment <input type="checkbox"/> Reading Skills <input type="checkbox"/> Basic Math Skills <input type="checkbox"/> Parent skills Other _____

Enrolled in Allegany County Board Of Education Pre-K?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of school _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
Enrolled in Allegany County Board Of Education Special Education?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of school _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
Enrolled in Infants and Toddlers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
My pediatrician or I have concerns about my child's...	<input type="checkbox"/> Speech <input type="checkbox"/> Thinking <input type="checkbox"/> Physical <input type="checkbox"/> Development
My child attends daycare:	Name: _____ Address: _____ <input type="checkbox"/> Mon. <input type="checkbox"/> Tues. <input type="checkbox"/> Wed. <input type="checkbox"/> Thurs. <input type="checkbox"/> Fri.
I am in need of child care...	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> AM <input type="checkbox"/> PM Both <input type="checkbox"/> Mon. <input type="checkbox"/> Tues. <input type="checkbox"/> Wed. <input type="checkbox"/> Thurs. <input type="checkbox"/> Fri.

