Allegany County Human Resources Development Commission, Inc.
Department of Children & Family Services
125 Virginia Avenue
Cumberland, MD 21502
301-783-1730
FAX#: 301-876-9081
TTY/TDD 1-800-982-9877
This institution is an equal opportunity provider.

Primary Adult Name: _____ I am applying for: (check all that apply)
□ Head Start Child (ages 3-5)
□Early Head Start (birth-3yrs)

Child Applicant Information

Last	First	MI	Preferred	Suffix
Birthday	**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: □ On Medicaid □ Not Eligible □ 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
○ Asian ○ Black ○ White ○ Native American ○ Pacific Islander ○ Other	**English**			**0-None** **1-Poor** **2-Moderate** **3-Proficent**
Nationality			**Ethnicity**	

****VERY IMPORTANT****

Please send copies of the following items (# 1-3 below) with this registration in order for it to be processed.

1) **PROOF OF INCOME** (all that are checked in the Family Income Support Section)
2) **CHILD'S SOCIAL SECURITY CARD**
3) **CHILD'S BIRTH CERTIFICATE or OTHER PROOF OF AGE**
4) **UPDATED IMMUNIZATION RECORD (can be provided once accepted into program)**
5) **COMPLETED PHYSICAL BY PHYSICIAN (can be provided once accepted into program)**

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 have recent screening from the dentist.

Primary Adult Member Information

(Complete for each non-applicant family member)

□ Primary Adult				
Last Name	**First Name**	**Middle**	**Preferred**	**Suffix**
Birthday	**SSN** - -	**Gender: □ Male □ Female**		

Relationship to Child?	**Provides Financial Support To This Family □ Yes □ No**
Do you have custody? □ Yes □ No	**Teen Parent?** □**Yes** □**No**
Present Employment Status: □**Full Time (35hr.wk)** □ **Full Time Work and School** □**Part Time Work** □**Part Time Work and School** □**Retired or Disabled** □**Seasonally Employed** □ **Training or School Only** □**Unemployed**	**Highest Level of Education Completed:** □**Grade 9 or less** □**Grade 10** □**Grade 11** □**High School Grad** □**GED** □**Technical/Advance Training** □**Associate's Degree** □**Bachelor's Degree** □**Master's Degree**
Do You Live in the Household with the Child? □**Yes** □ **No**	**Current Housing Situation:** □**Owns Home** □**Rents** □**Stays with Family or Friends** □**Stays in a Hotel/Motel** □**Stays in a Temporary Shelter** □**Literally Homeless (No Fixed Nighttime Residence)** □**Other, Please Explain:**

Primary Adult's Health Coverage

Medicaid Eligibility Status: □ On Medicaid □ Not Eligible □ 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**
o Asian o Black o White o Native American o Pacific Islander o Other	**English**			**0-None** **1-Poor** **2-Moderate** **3-Proficent**
US Citizen □Yes □No If no, where?			**Ethnicity:**	
Marital Status:				

Primary Adult's Employment

I am currently working, attending school or am in training. □**Yes** □**No** **If yes, please specify where:**	**If currently working, how long have you been at your current job?**	**I have a severe health condition.** □**Yes** □**No**	**Is transportation an on going problem for your family?** □**Yes** □**No** **If yes, why?**
Are you a Veteran? □**Yes** □**No**			

Secondary Adult Member Information

(Complete for each non-applicant family member)

□ Secondary Adult				
Last Name	**First Name**	**Middle**	**Preferred**	**Suffix**
Birthday	**SSN** - -	**Gender: □ Male □ Female**		

Relationship to Child?	**Provides Financial Support To This Family □ Yes □ No**
Do you have custody? □ Yes □ No	**Teen Parent?** **□Yes □No**
Present Employment Status: **□Full Time (35hr.wk)** **□ Full Time Work and School** **□Part Time Work** **□Part Time Work and School** **□Retired or Disabled** **□Seasonally Employed** **□ Training or School Only** **□Unemployed**	**Highest Level of Education Completed:** **□Grade 9 or less** **□Grade 10** **□Grade 11** **□High School Grad** **□GED** **□Technical/Advance Training** **□Associate's Degree** **□Bachelor's Degree** **□Master's Degree**
Do You Live in the Household with the Child? □Yes □ No	**Current Housing Situation:** **□Owns Home** **□Rents** **□Stays with Family or Friends** **□Stays in a Hotel/Motel** **□Stays in a Temporary Shelter** **□Literally Homeless (No Fixed Nighttime Residence)** **□Other, Please Explain:**

Secondary Adult's Health Coverage

Medicaid Eligibility Status: □ On Medicaid □ Not Eligible □ 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**
o Asian o Black o White o Native American o Pacific Islander o Other	**English**			**0-None** **1-Poor** **2-Moderate** **3-Proficent**
US Citizen □Yes □No If no, where?			**Ethnicity:**	
Marital Status:				

Secondary Adult's Employment

I am currently working, attending school or am in training. **□Yes □No** **If yes, please specify where:**	**If currently working, how long have you been at your current job?**	**I have a severe health condition.** **□Yes □No**	**Is transportation an on going problem for your family?** **□Yes □No** **If yes, why?**
Are you a Veteran? **□Yes □No**			

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: □ **On Medicaid** □ **Not Eligible** □ **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
o Asian o Black o White o Native American o Pacific Islander o Other	**English**			**0-None** **1-Poor** **2-Moderate** **3-Proficent**
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: □ **On Medicaid** □ **Not Eligible** □ **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
o Asian o Black o White o Native American o Pacific Islander o Other	**English**			**0-None** **1-Poor** **2-Moderate** **3-Proficent**
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.

□ **Morning only from _____AM to _____PM**
Who takes care of your child in the afternoon? _____
□ **Afternoon only from _____PM to _____PM**
Who takes care of your child in the morning? _____
□**Morning and afternoon from _____AM to _____ PM**
□**Evening from _____PM to _____PM**

Would you enroll your child for 9 months or 12 months? □ 9 months □ 12 months

If not 12 months, who takes care of your 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 socialization days would be scheduled twice a month for playgroup experience. □ Yes □ No

If yes, when would you like your personalized program?
□ **Weekdays** □ **daytime or** □ **evening after 5pm.**
□ **Saturdays** □ **daytime or** □ **evenings after 5pm.**

How could the Head Start Program further assist you with your current childcare needs?
Please check all that apply:
□ **Inform me about childcare in the community and how I can get the services I need.**
□ **Provide infant and toddler childcare at the Head Start Center.**
□ **Provide before school care at the Head Start Center for my school age children.**

What areas would you be interested in obtaining information about?
□ **Employment** □ **Reading Skills** □ **Basic Math Skills** □ **Parent Skills** □ **Financial Education**

Other _____.

Is your child enrolled in Allegany County Board Of Education Pre-K?		□ **Yes** □ **No** **If yes, name of school _____** □**AM** □ **PM**	
Does your child receive Special Education Services from the Allegany County Board of Education, including the Birth to 5 Program and/or Infants and Toddlers? I give permission for the Allegany County Board of Education to release relevant education information/data regarding my child, including an IEP/IFSP (Individual Education Plan/Individual Family Service Plan).		□ **Yes** □ **No** **If yes, name of school _____** □ **Yes** □ **No**	
My pediatrician or I have concerns about my child's…		□ Speech □ Thinking □ Physical Development □ Other:	
My child attends daycare:	Name:	Address:	□ Mon. □ Tues. □ Wed. □ Thurs. □ Fri.
I am in need of child care...	□ **Yes** □ **No**	□ **AM** □ **PM** □**Both**	□ Mon. □ Tues. □ Wed. □ Thurs. □ Fri.

Do you have a child currently enrolled in the Head Start/Early Head Start Program? □ Yes □ No

Primary Site	Parental Status: One / Two	Primary Language At Home	
Number in Family	Number of Children_____ By age: 0-3 ___ 4-5____		Number in Household _____

Family Income Support

SNAP: □ Yes □ No	TANF/TCA: □ Yes □ No	SSI: □ Yes □ No	WIC □Yes □ No

Family Income

Family Member	Date	Source	Amount	How Often	Annual Amount	Type	Description	Verification

Type Code	Description Codes	Verification Codes	
ERN-Earned	PEN-Pension SSI – SSD -	CS-Check Stub	W2 – W2
SUB- Subsidized	SS- Social Security	EL- Employer Letter	TAN- TANF

Pregnant Women Program Information

What is your due date? _____

Who is your OB/GYN? _____

Do you participate in Healthy Start? □ Yes □ No

Are you enrolled in WIC? □ Yes □ No

Has your doctor indicated that this is a high risk pregnancy? □ Yes □ No

Have you been referred to another doctor or specialist? □ Yes □ No

Certification: I certify that this information is true. If any part is false, my participation in this agency's program may be terminated and I may be subject to legal action. 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.

Parent / Guardian Signature _____ Date _____

There is a completed Head Start Eligibility Verification Form for this child/family:
Yes_____ No _____ (check one)

Verifying Staff Member _____Date___ _____