

EAST BATON ROUGE PARISH HEAD START/EARLY HEAD START PROGRAM

4523 Plank Road
 Baton Rouge, Louisiana 70805
 (225) 358-4504



2016 APPLICATION

A TRADITION OF EXCELLENCE

- EARLY CHILDHOOD EDUCATION - COMMUNITY PARTNERSHIP/VOLUNTEERISM
- NUTRITIOUS MEALS AND SNACKS - COMPREHENSIVE CHILD AND FAMILY DEVELOPMENT SERVICES
- MEDICAL AND DENTAL SERVICES - SOCIAL SERVICES FOR FAMILIES
- ACTIVITIES FOR PARENTS - ASSISTANCE FOR CHILDREN WITH SPECIAL NEEDS

CENTER LOCATIONS		
Capital Area Early Head Start	Children’s Early Head Start	Discovery Early Head Start
3250 N. Acadian Thruway E. Baton Rouge, LA 70805 (225) 806-6023	7200 Maplewood St. Baton Rouge, LA 70812 (225) 355-9776	9700 Scenic Hwy. Baton Rouge, LA 70807 (225) 775-7719
Ages 18 months – 2 years	Pregnant Women; Ages 6 months- 2 years	Ages 6 month – 2years

The following information must be submitted with your application:

- Applicant’s Birth Certificate/Verification of Birth
- Applicant’s Immunization Card (up-to-date)
- Notarized proof of guardianship (if applicable)
- Social Security Cards for each family member
- Applicant’s Medical Card or Health Insurance Card
- Verification of Disability (if applicable)
- Proof of Income: Relevant Time Period- **FROM** _____ **TO** _____
 - Payroll Check Stub (Must have name of company, name of employee, year to date income, hourly pay, pay period) within “Relevant Time Period”
 - All W2’s for “Relevant Time Period”
 - Income Tax Return – 1040 (preceding year)
 - FITAP (welfare)– Budget Slip
 - Social Security Statement
 - Social Security Income (SSI) Statement
 - Child Support Documents
 - Unemployment Compensation
 - Self-employment Statement
 - Non-Income Verification or Self-Declaration and Third Party Agreement

RELEVANT TIME PERIOD - (A) the 12 months preceding the month in which the application is submitted; or (B) during the calendar year preceding the calendar year in which the application is submitted, whichever more accurately reflects the needs of the family at the time of application.

Please do not detach sheets, last page requires signature

An Equal Opportunity Program

FEDERAL LAW PROHIBITS DISCRIMINATION BECAUSE OF RACE, COLOR, RELIGION, SEX, AGE, NATIONAL ORIGIN, AND/OR

East Baton Rouge Parish Head Start/Early Head Start Program

DATE
STAMP

Center applying for (choose one only) **Children's World** **Capital Area** **Discovery**

Referring Agency _____

Contact Person _____ Telephone # _____

I. EXPECTANT MOTHER'S INFORMATION

Expectant Mother's Name _____

Anticipated Date of Delivery: _____ Prenatal Physician: _____ Address: _____

Phone #: _____

PARENT'S INFORMATION

Parent/Guardian's Name: _____ DOB: _____ Mother Father Grandparent Other

SSN: _____ Race/Ethnicity (optional): African American/Black Asian Caucasian/White Hispanic/Latino Other _____

Address: _____ Home Telephone #: _____ Cell Phone #: _____

City: _____ State: _____ Zip: _____

Place of Employment: _____ Work Phone: _____

Parent's Martial Status: Single Married Divorced Separated **Child lives with?** Mother Father Legal Guardian

II. CHILD'S INFORMATION

Child's Name: _____

Date of Birth: _____ Age: _____ Social Security #: _____ - _____ - _____ Gender: Male Female

Race/Ethnicity: (Optional)

African American / Black Asian Caucasian / White Hispanic / Latino Native American / Alaskan Other: _____

Language Spoken at Home: Primary: _____ Secondary: _____

III. CHILD'S HEALTH INFORMATION: (Submit copy of Health Insurance Card)

No Health Insurance LaCHIP #: _____ MEDICAID #: _____

Health Insurance Company: _____ Policy #: _____

Primary Care Physician: _____

Address: _____ Telephone #: _____

Dentist: _____

Address: _____ Telephone #: _____

IV. EMERGENCY CONTACTS

In case of Emergency Contact: (Check all applicable). **In case of emergency your child will be transported to the nearest hospital.**

Name: _____ Telephone #: _____ Medical Personnel 911 Share Medical Health Records

In addition to Emergency Contact, child may be released to:

Name: _____ Home phone #: _____ Cell Phone #: _____

Name: _____ Home phone #: _____ Cell Phone #: _____

Name: _____ Home phone #: _____ Cell Phone #: _____

Name: _____ Home phone #: _____ Cell Phone #: _____

Medical Conditions / Disabilities: (Submit copy of medical reports/IFSP relating to Conditions)

Allergies Type: _____ Autism Traumatic Brain Injury
Birth Defects Developmental Delay Speech / Language
Diabetes Dietary restrictions Type: _____ Sickle Cell Anemia
Emotional / Behavior Disorder Epilepsy / Seizures Mental Retardation
Health Impairment Hearing Impairment / Deafness Orthopedic Impairment
Visual Impairment / Blindness Learning Disability Type: _____ Other: _____

FAMILY INFORMATION

Living Arrangement <input type="checkbox"/> Two Parents <input type="checkbox"/> Single parent – Mother Only <input type="checkbox"/> Single parent – Father Only <input type="checkbox"/> Single parent / Mother & Partner <input type="checkbox"/> Single parent /Father & Partner <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Grandparent

Housing <input type="checkbox"/> Own/Buying <input type="checkbox"/> Renting House <input type="checkbox"/> Apartment <input type="checkbox"/> Homeless/ Shelter <input type="checkbox"/> Public Housing Assistance <input type="checkbox"/> Other_____
How Long at this address _____ Has family moved 2 or more times in the last 12 months? <input type="checkbox"/> YES <input type="checkbox"/> NO

Transportation Private Vehicle Public Transportation Friend / Relative Other:_____

Relationship	<input type="checkbox"/> Mother <input type="checkbox"/> Grandmother <input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Father <input type="checkbox"/> Grandfather <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other
Name		
Date of Birth		
Age		
Social Security Number		
Race/Ethnicity	<input type="checkbox"/> African American / Black <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian / White <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Native American / Alaskan <input type="checkbox"/> Other:_____	<input type="checkbox"/> African American / Black <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian / White <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Native American / Alaskan <input type="checkbox"/> Other:_____
Language	Primary_____ Secondary_____	Primary_____ Secondary_____
Education	<input type="checkbox"/> College /Advance Degree <input type="checkbox"/> Associate Degree <input type="checkbox"/> Some College <input type="checkbox"/> High School Diploma /GED <input type="checkbox"/> 12 th grade <input type="checkbox"/> 11 th grade <input type="checkbox"/> 10 th grade <input type="checkbox"/> 9 th grade <input type="checkbox"/> ≥8 th grade	<input type="checkbox"/> College /Advance Degree <input type="checkbox"/> Associate Degree <input type="checkbox"/> Some College <input type="checkbox"/> High School Diploma /GED <input type="checkbox"/> 12 th grade <input type="checkbox"/> 11 th grade <input type="checkbox"/> 10 th grade <input type="checkbox"/> 9 th grade <input type="checkbox"/> ≥8 th grade
Employment	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Disabled <input type="checkbox"/> In-School/Training <input type="checkbox"/> Unemployed: <input type="checkbox"/> with previous experience <input type="checkbox"/> with no previous experience <input type="checkbox"/> Other_____	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Disabled <input type="checkbox"/> In-School/Training <input type="checkbox"/> Unemployed: <input type="checkbox"/> with previous experience <input type="checkbox"/> with no previous experience <input type="checkbox"/> Other_____
Work Phone #		Work Phone #
Other Public Assistance:	<input type="checkbox"/> Medicaid / Medicare <input type="checkbox"/> Food Stamps <input type="checkbox"/> WIC <input type="checkbox"/> Child Care Assistance <input type="checkbox"/> Other:_____	<input type="checkbox"/> Medicaid / Medicare <input type="checkbox"/> Food Stamps <input type="checkbox"/> WIC <input type="checkbox"/> Child Care Assistance <input type="checkbox"/> Other:_____
Special Conditions / Concerns:	Medical Conditions / Disabilities <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, describe:_____ Health Insurance <input type="checkbox"/> YES <input type="checkbox"/> NO Currently Pregnant <input type="checkbox"/> YES <input type="checkbox"/> NO Substance Abuse <input type="checkbox"/> YES <input type="checkbox"/> NO Physical Abuse <input type="checkbox"/> YES <input type="checkbox"/> NO Legal Issues <input type="checkbox"/> YES <input type="checkbox"/> NO	Medical Conditions / Disabilities <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, describe:_____ Health Insurance <input type="checkbox"/> YES <input type="checkbox"/> NO Substance Abuse <input type="checkbox"/> YES <input type="checkbox"/> NO Physical Abuse <input type="checkbox"/> YES <input type="checkbox"/> NO Legal Issues <input type="checkbox"/> YES <input type="checkbox"/> NO

Relationship:	<input type="checkbox"/> Sibling <input type="checkbox"/> Non-Relative	<input type="checkbox"/> Sibling <input type="checkbox"/> Non-Relative
Name		
Date of Birth		
Age		
SS#		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Race/Ethnicity (Optional)	<input type="checkbox"/> African American / Black <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian / White <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Native American / Alaskan <input type="checkbox"/> Other: _____	<input type="checkbox"/> African American / Black <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian / White <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Native American / Alaskan <input type="checkbox"/> Other: _____
Language	Primary _____ Secondary _____	Primary _____ Secondary _____
Education	<input type="checkbox"/> Some College <input type="checkbox"/> High School Diploma /GED <input type="checkbox"/> <12 th grade	<input type="checkbox"/> Some College <input type="checkbox"/> High School Diploma /GED <input type="checkbox"/> <12 th grade

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Age		
SS#		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
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ACKNOWLEDGEMENT

I certify that, to the best of my knowledge, the information provided in this application is true and accurate. I understand that if any of this information changes or is found to be incorrect, I am obligated to notify this agency immediately. I understand that falsifying information such as family income, number of children, number of household members or relationship may result in the rejection of this application and my child being terminated from East Baton Rouge Parish Head Start/Early Head Start Program.

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Parent / Guardian's Name (PRINT): _____

Parent / Guardian's Signature: _____

Date: _____

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