APPLICATION COVER SHEET

(Must be complete and attached to all applications/files sent to Corporate for enrollment)

●CHILD NAME: ___________________________________ ●CHILD DATE OF BIRTH:__________________

●HACAP HOUSING: Yes No ● POINTS: ________ ●PROGRAM: ___________

●APPLICATION COMPLETED AT: ___________________________________ ●DATE: ________________

(location)

●SITE REQUESTED (1ST Choice) ___________________________(2nd Choice)__________________________

●CURRENT SCHOOL DISTRICT ____

FAMILY NEED HS Full Day (10 hr.)_____ HS School Day (8 hr.)_____ HS Part Day (4 hr) Mon-Fri____
EHS Center Based (10 hr.)____ EHS Home Based_____

FAMILY INFO (Misc.)

1. What is the best way to contact you? Email____ Email Address:________________________________
Phone____ Phone No.____________________ Text_____ Letter ____
________*Initial here to authorize this method of communication*
2. Health Insurance through____________________________ Policy Number: ______________________
3. DHS Child Care Assistance (DHS CCA): Applied________ Receiving_______
4. How did you hear about Head Start? ____

ABBREVIATED NUTRITION ASSESSMENT – Must be completed at time of application

1. Parent concerns about child eating in the Head Start classroom? Yes No

2. Any special diet modifications child must follow? Yes No
(i.e. medical diet, food allergies)
If yes, a Food Allergy/Special Medical Diet Form must be completed and sent to the CACFP Manager. Please complete and attach.

3. Any religious dietary restrictions we should know about? Yes No
If yes, explain ____

4. Are you participating in WIC? Yes No
If yes, when was the child's last certification? ________________

5. Are you receiving food stamps/SNAP? Yes No

6. Are you able to provide adequate meals for your family? Yes No
(i.e. do you run out of food*, does your refrigerator/stove work?) *Encourage community resources as needed

SPECIAL NEEDS – Must be completed at time of application

1. Suspected Disability Yes No
If yes, suspected disability reported by: ________________________________

2. Professionally Diagnosed Disability Yes No
If yes, describe: ____
Disability professionally diagnosed by: ________________________________

Documented diagnosis/verification included with application **Yes No**
included with application?

3. Special Health Concerns Yes No
If yes, describe: ____

Flag for Review
Red – Health
Blue – Disability
Yellow – Nutrition
Green – Other
ATTACH FLAG HERE

Hawkeye Area Community Action Program, Inc.
1515 Hawkeye Drive, PO Box 490, Hiawatha, IA 52233

Basic Intake Form – HS/EHS

Child's Last Name_______________________________ Child's First Name___________________________ MI____

Street Address____ City____________________ State______ Zip__________

Mailing Address (if different) _______________________________________ City____________________ State______ Zip__________

Primary Phone # (home/cell) _________________________ Alternate Phone # (cell/work/message/emergency)__________________________

HOUSING: ❑Own or Buying ❑Renting ❑Homeless (complete back page) ❑Other explain _____________________(complete back page)

FAMILY TYPE: ❑Female single parent ❑Male single parent ❑Two parent Household

Total # of Household Members: _____ #of children _____ By age: 0-3____ 4-5 ____

Veteran in Family (indicate family member) _________________ **Native language if other than English:**________________________

HOUSEHOLD MEMBERS ***(including yourself; If more than 5 members please continue on the back of this form)***

	Name (first and last)	Relationship to Applicant	Date of Birth	Sex	Hispanic or Latino	Race	Ed. Level	Employment Status	Disability **Y** or **N**	Medical Insur.
Primary Adult					Yes No					
Secondary Adult or Child					Yes No					
Child					Yes No					
Child					Yes No					
Child					Yes No					

Codes

Education Level		Employment Status		Medical Insurance	
COL-College/Advanced Training	G9-Grade 9 or less	F-Full Time (28+hrs/wk)	B-Full Time & Training	XIX	Other
CTG-Training Cert.	G10-Grade 10	P-Part Time	L-Part Time & Training	Hawk-I	
HSG-High School Grad	G11-Grade 11	R-Retired or Disabled	S-Seasonally Employed	Private	
GED-General Education Diploma	G12-Grade 12	T-Training or School	U-Unemployed	None	

INCOME SOURCES

****Proof of Income will be required to process application**

Income received in the last year (check all that apply)

	Primary Adult	Secondary Adult
Work	❑	❑
SSI	❑	❑
Social Security	❑	❑
FIP/TANF/SNAP	❑	❑
Unemployment	❑	❑
Scholarships	❑	❑
Grants	❑	❑
Child Support	❑	❑
Other (explain)	❑____________	❑_____________

Emergency Contacts

(Other than parents)

#1
Name: ________________________________Relationship ___________
Address: ____
City/State/Zip____
Phone: H/C/M/W: ( )____
Emergency Contact? ❑Yes ❑No
Release To? ❑Yes ❑No

#2
Name: ________________________________Relationship ___________
Address: ____
City/State/Zip____
Phone: H/C/M/W: ( )____
Emergency Contact? ❑Yes ❑No
Release To? ❑Yes ❑No

Doctor:
Name________________________ Phone: _________________
Address:______________ City:_______________ State:_____

Dentist:
Name________________________ Phone: _________________
Address:_______________ City:_______________ State:_____

Hospital Preference: ________________ Phone: ______________
Address:_________________________ City:__________ State ____

I have carefully reviewed the information in this form and by signing this application, certify to the best of my knowledge and belief that all information in this application is true and correct. I further understand that this is an application for services that are paid with federal funds and that intentionally providing misleading, inaccurate or untruthful information of a material nature could result in dis-enrolling my child from Head Start Early Head Start and is considered fraud and could have serious legal consequences for me.

Parent/Guardian signature: X____ Date: ______________________

Verifying Staff Member: X____ Date: ______________________

APPLICANT'S NAME:_______________________________

ADDITIONAL HOUSEHOLD MEMBERS

	Name (first and last)	Relationship to Applicant	Date of Birth	Sex	Hispanic or Latino	Race	Ed. Level	Employment Status	Disability **Y** or **N**	Medical Insur.
Child					Yes No					
Child					Yes No					
Child					Yes No					
Child					Yes No					
Child					Yes No					
Child					Yes No					
Child					Yes No					
Child					Yes No					
Child					Yes No					
Child					Yes No					
Child					Yes No					
Child					Yes No					

Codes

Education Level		**Employment Status**		**Medical Insurance**	
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Parent/Guardian signature: **X**____ Date: ____________________

Verifying Staff Member: **X**____ Date: ____________________