Jackson-Vinton Community Action Head Start
ENROLLMENT APPLICATION
320 W. South St. Jackson, OH 45640
(740) 286-8441 or 1-866-471-4455
Fax: 1-740-286-0803

It is the responsibility of Head Start personnel to maintain confidentiality and protect the privacy of Head Start children and families. Head Start parents also have the right to review child and family records and to request an explanation for information in those records as well as how it is used.

Child's full name _____ Sex: M F Age: _____

Child's Address _____
City Zip County

What language does your child speak fluently?_____Primary language family speaks?_____

Birth Date _____ Race _____ Social Security # _____

Mother/Guardian name _____ Phone #_____ DOB _____Race_____
(required)

Mother/Guardian Address _____
(If different from child) City Zip County

Highest grade mother completed in school: _____

Father/Guardian name _____ Phone #_____ DOB _____ Race_____
(required)

Father/Guardian Address _____
(If different from child) City Zip County

Highest grade father completed in school:_____

List other children (under age 21) in the home:

Name	DOB	Name	DOB
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Total Number Living in Household _____ Single Parent Household? Y N

Employment **Complete this section for parent (s) living in home with child.**

Is mother employed or attending school? Employed Full-Time Employed Part-Time Unemployed Attending School
(Circle all that apply) Military ____Yes ____No

Is father employed or attending school? Employed Full-Time Employed Part-Time Unemployed Attending School
(Circle all that apply) Military ____Yes ____N


More questions on back of form

Health Provider Information

Please circle which applies: Medicaid/EPSDT Care Source Molina United Health Care

No Insurance Private Insurance _____

Is this a foster child? Y N Is your family receiving cash assistance? Y N

Is your family homeless? Y N Do you need assistance with housing? Y N

Who does the child live with? _____Mom _____Dad ____Other please explain:_____

Do you receive food stamps? Y N Do you receive WIC? Y N

Voluntary Child Information

Please list any disability or special need of your child _____

Is this special need or disability documented by a physician or therapist? Y N

If yes, please give us the name of the physician or therapist _____

Does your child have an IEP through a school system? Y N

If yes, please name the school system _____

Additional information you would like for us to know _____

I hereby make application for my child _____, to be enrolled in the Head Start program and agree to accept the Center Based option according to availability. I also confirm that the information contained on this form is true and correct.

Signature _____ Date _____
(Parent/Guardian)

*Please Note: This application will not be considered complete until we have your proof of income, which may include one of the following: Most recent check stub, W-2, Income tax form, proof of cash assistance from ODJFS, proof of child support, unemployment check stub, written statement from employer, foster care reimbursement, SSI documentation or Zero Income form.
How did you hear about Head Start? _____

Do you have an email address?_____

Head Start the best start!

*JVCAI & USDA are equal opportunity Employer/Provider of services.

For Office Use Only

_____Age

_____Over Signature of Head Start Staff _____

_____Under

_____ 101%-130%

Income Amount $_____ yearly