EightCAP, Inc. 0-5 Head Start Infant/Toddler Application

(CLINTON, GRATIOT, IONIA, ISABELLA & MONTCALM COUNTIES)

Child1 Name:_____ Date of Birth:_____ Sex: ☐ Male ☐ Female

Child2 Name:_____ Date of Birth:_____ Sex: ☐ Male ☐ Female

Parent/Guardian1_____ Date of Birth:_____ Relationship:_____

Parent/Guardian2_____ Date of Birth:_____ Relationship:_____

County:_____ School District in which you live:_____ E-Mail Address:_____

Address:_____

(Street) (P.O. Box) (City) (Zip)

Phone***1***_____ ☐Cell☐Home ☐Mess Phone***2***_____ ☐Cell☐Home ☐Mess **TEXT** Messages ☐Yes☐No

Were you under 20 years old when your first child was born? ☐Yes ☐No

Has child attended any Early Childhood Programs?: ☐Yes ☐No if yes,where_____

Does child have an IFSP (Individual Family Service Plan)?: ☐Yes ☐No if yes, which Child _____

My signature below authorizes any Intermediate School District to share my child's educational records with EightCAP, Inc. 0-5 Head Start. ☐Yes ☐No

Was child ever involved with *Early On?*: ☐Yes ☐No

Is child in a foster care placement?: ☐Yes ☐No

Are you homeless (lack of a fixed, regular, and adequate nighttime residence)? ☐Yes ☐No

Are you expecting the birth of a child? ☐Yes ☐No if yes,when_____

Please choose which program opportunity works best for you:

☐ ***Home*-based** (weekly home visits) offered in Clinton, Gratiot, Ionia, Isabella & Montcalm counties

☐ ***Center*-based** (available to Teen Parents and families involved with Child Protective Services) offered in Clinton, Gratiot, Isabella & Ionia

Additional information we should know about your child (parental/behavioral/developmental concerns or health issues, etc.)?:

Child lives with? ☐ Both Parents ☐ Mother ☐ Father ☐ Other: _____

Number of siblings: _____

Does your family receive any of the following?: ☐ DHS Food Assistance ☐ WIC

Parent/Guardian 1: Total of all Gross Income (Verification of income will be required): $ _____

Choose the period the above total represents: ○Weekly ○ Bi-weekly ○ Monthly ○ Annually

Income Source: (check all that apply): ☐ Working ☐ Child Support ☐ SSI ☐ DHS Financial ☐ Other: _____

Parent/Guardian 2: Total of all Gross Income (Verification of income will be required): $ _____

Choose the period the above wage represents: ○Weekly ○ Bi-weekly ○ Monthly ○ Annually

Income Source: (check all that apply): ☐ Working ☐ Child Support ☐ SSI ☐ DHS Financial ☐ Other: _____

Any income changes in the last 6-12 months (i.e., unemployment, wage increase/decrease, etc.)?:

_____

This is an application **only** and **does not** guarantee your child will be enrolled into a program. Eligibility is based on a child's age, family income, child's need & available openings.

I hereby release this information and educational records to be shared between EightCAP, Inc. 0-5 Head Start, local school districts, and any Intermediate School District. My signature verifies that the above information is correct and true to the best of my knowledge.

Parent/Guardian Signature: _____ **Date**: _____

Please return to: **Infant Toddler Application Committee, 904 Oak Dr. Greenville, MI 48838-8230**

Fax: 616-754-9310 E-mail: deniseb@8cap.org Apply online: www.8cap.org

For more information, call 1-866-754-9315, ext. 3369 or Michigan Relay Center: 1-800-649-3777 (Voice & TDD)

How did you hear about your local program: ☐ Advertisement ☐ Community Organization ☐ Event

☐ Friend/Family Member ☐ Older Children Attended ☐ School ☐ EightCAP, Inc. Website/Staff

State & Federally funded programs will not discriminate against anyone because of race, color, national origin, sex, age or disability, except as prescribed by program guidelines.

FOR OFFICE USE ONLY Reviewed by:_____ Date:_____ Inc :_____ Age (as of 9-1)_____

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CHILD'S NAME _____ COUNTY_____

PARENT'S NAME _____ PHONE NUMBER _____

NEEDS ASSESSMENT

1. Are you: ☐ single ☐ married ☐divorced ☐widowed ☐separated
2. How much schooling have you completed?
   ☐ 6th ☐7th - 8th grade ☐9th - 10th grade ☐11th grade ☐ 12th grade ☐GED ☐College
3. Were you under 20 years old when your first child was born?: ☐yes ☐no
4. Have you lived in more than 2 homes in the past three (3) years?: ☐yes ☐no
5. Has anyone in your home ever been a victim of physical/domestic/sexual abuse or neglect?: ☐yes ☐no
6. Do you reside in a high-risk neighborhood (high poverty, crime or limited access to critical resources)?: ☐yes ☐no
7. Have your children suffered a parental loss due to death, divorce, incarceration, military service or absence?: ☐yes ☐no
8. Has your child ever been expelled from a child care center?: ☐yes ☐no
9. Has your child ever been exposed to a toxic substance?: ☐yes ☐no If yes, what substance_____
10. <u>In the past 2 years have you or members of your household</u>:

Experienced difficulty in obtaining medical services?	☐yes	☐no
Used the emergency room?	☐yes	☐no
Received a shut-off notice from a utility company?	☐yes	☐no
Been homeless?	☐yes	☐no
Ever been without heat?	☐yes	☐no
Used a food bank or pantry?	☐yes	☐no

11. How many people are living in your home? _____

    Name: _____ Date of Birth: _____ Relationship to applicant child:_____
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12. Primary Language spoken in your home?: ☐English ☐Spanish ☐Other _____
13. What is the Primary Language spoken by your child(ren)?: ☐English ☐Spanish ☐Other _____

The information gathered is used to help develop a Community Needs Assessment. No personal information will ever be shared.