



# Community Action Partnership

Huntsville/Madison & Limestone Counties Inc.

Child's Name \_\_\_\_\_

DOB \_\_\_\_\_ SSN \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Address/City \_\_\_\_\_

Phone Number \_\_\_\_\_

Name and Phone Number Where Message Can Be Left \_\_\_\_\_

DOB \_\_\_\_\_ SSN \_\_\_\_\_

If employed, in school or in a training program, please complete the following:

Name of Employer or School

\_\_\_\_\_

Address/Phone Number of Employer/School

\_\_\_\_\_

Hours work or in school per week \_\_\_\_\_ Hourly Rate of Pay \_\_\_\_\_

## OTHER FAMILY MEMBERS LIVING IN HOUSEHOLD

Last Name	First Name	SSN	DOB	Relationship	Gender

**Information required for all persons in household:** Proof of income (past 12 months), immunization certificate (Blue slip), copies of Social Security cards of everyone in the household, copy of the Medicaid card for the child to be enrolled (*if applicable*), original birth certificate of child

**\*\* If any questions please contact the Central Office: 851-9804 or 851-2246**

**IT IS IMPORTANT THAT YOU ANSWER ALL OF THE FOLLOWING QUESTIONS ACCURATELY. THE INFORMATION YOU PROVIDE BELOW IS USED TO DETERMINE A NUMERICAL CODE. IF YOUR CHILD IS PLACED ON A WAIT LIST, THIS CODE IS USED TO DETERMINE PRIORITY.**

Did someone refer you to Head Start? \_\_\_ Y \_\_\_ N

If so, please specify who \_\_\_\_\_

**If an agency, professional or school has referred you, please have them forward us a letter of referral for the purpose of coding.**

Do you currently have any other children attending Head Start? \_\_\_ Y \_\_\_ N

Does this child have a diagnosed special need(s)? \_\_\_ Y \_\_\_ N If yes, please have agency and/or physician send a letter of referral for the purpose of verification and coding.

Do you have any medical concerns with this child? \_\_\_ Y \_\_\_ N

Please Specify \_\_\_\_\_

Are you or any of your immediate family experiencing any of the following circumstances?

\_\_\_ Homelessness \_\_\_ Victim of Domestic Abuse

\_\_\_ Serious Health Problems \_\_\_ Substance Abuse

\_\_\_ Involved with DCYF \_\_\_ Receiving counseling or support services

(Department of Children Youth and Families)

Have you received your high school diploma or GED? \_\_\_ Y \_\_\_ N

If this is **not** your biological child are you their:

\_\_\_ Foster Parent

\_\_\_ Legal Guardian

\_\_\_ Other (Please Specify \_\_\_\_\_)

What is your primary language spoken at home? \_\_\_\_\_

Parent Signature Date \_\_\_\_\_

Office Use Only:	Date Received _____	Code _____
	Date Screened/Accepted _____	WL Letter Sent _____