

# MIDDLE GEORGIA COMMUNITY ACTION AGENCY, INC. HEAD START PROGRAM ENROLLMENT APPLICATION

## APPLICANT INFORMATION

Center Name: \_\_\_\_\_ Eligibility Status: \_\_\_\_\_

|   |  |                                   |
|---|--|-----------------------------------|
| Child's Last Name   | Child's First Name                                   | Child's Middle/Preferred Name     |
| DOB (mm/dd/yyyy):   | SSN:   | Gender: <b>Male</b> <b>Female</b> |
| <b>Race</b> (check all that apply):<br>Black    Hispanic<br>White    Amer. Indian/Alaska Native<br>Asian    Native Hawaiian/Pacific Islander<br>Other _____ | Primary Guardian's Relationship to Child             | Nation Origin:                    |
|   | Primary Language: _____<br>Secondary Language: _____ | Ethnicity:                        |

### FAMILY INFORMATION

|                                |       |     |        |
|--------------------------------|-------|-----|--------|
| Living Address                 |       |     |        |
| City                           | State | Zip | County |
| Mailing Address (If different) |       |     |        |
| City                           | State | Zip |        |

### PHONE NUMBERS

(If more space is needed use back of form)

**Phone Type Codes:** **H**-Home **W**-Work **C**-Cell **M**-Message **P**-Pager/Beeper

| Type | √ if Primary (Check One) | Phone Number | Note |
|------|--------------------------|--------------|------|
|      |                          | (    )       |      |
|      |                          | (    )       |      |
|      |                          | (    )       |      |

### MEMBERS IN HOUSEHOLD

**If guardians are not child's natural parents please complete FCP Form 94A.**

#### CODES

| * Employment Codes  |                          | ** Education Codes   |                                  |                                  |
|---|--------------------------|--|----------------------------------|----------------------------------|
| F-Full Time(35+hrs/wk)  | T-Training or School     | G9-Grade 9 or Less   | HSG-High School Graduate         | CTG-College Graduate/Certificate |
| P-Part Time   | S-Seasonally Employed    | G10-Grade 10   | GED-General Education Diploma    | A-Associates Degree              |
| R-Retired or Disabled   | U-Unemployed             | G11-Grade 11   | COL-College/Tech Training        | B-Bachelor's Degree              |
|   |                          | G12-Grade 12   |                                  | M-Masters Degree                 |
| <b>Primary Guardian</b>   |                          | <b>Relationship to child:</b> Mother    Father    Grandparent    Friend    Other _____ |                                  |                                  |
| Last  |                          | First    SSN   |                                  |                                  |
| DOB   | Gender: Male<br>Female   | Provides Financial Support: <b>Yes</b> <b>No</b>                                       |                                  |                                  |
| Employment Status*: _____   | Education Level**: _____ | Teen Parent: <b>Yes</b> <b>No</b>  | Subsidized: <b>Yes</b> <b>No</b> |                                  |
| Place of Employment:  |                          | Work Address:  | Work Phone #:                    |                                  |
| <b>Secondary Guardian</b> (Only if Applicable<br>Secondary Guardian is Living in Household) |                          | <b>Relationship to child:</b> Mother    Father    Grandparent    Friend    Other _____ |                                  |                                  |
| Last  |                          | First    SSN   |                                  |                                  |
| DOB   | Gender: Male<br>Female   | Provides Financial Support: <b>Yes</b> <b>No</b>                                       |                                  |                                  |
| Employment Status*: _____   | Education Level**: _____ | Teen Parent: <b>Yes</b> <b>No</b>  | Subsidized: <b>Yes</b> <b>No</b> |                                  |
| Place of Employment:  |                          | Work Address:  | Work Phone #:                    |                                  |

ATTACH: Copy of child's birth certificate & Social Security Card  
Copy of verification of income for all family members & Childs up to date immunization record

CHILD'S NAME \_\_\_\_\_ CENTER \_\_\_\_\_

| Other Children living in Home<br>(If more space is needed use back of form) |                                    |                        |  |        |              |
|---|------------------------------------|------------------------|--|--------|--------------|
| First and last name   | Please enter one of the following: |                        |  | Gender | Relationship |
|   | DOB                                | Social Security Number |  |        |              |
|   |                                    | - -                    |  | M F    |              |
|   |                                    | - -                    |  | M F    |              |
|   |                                    | - -                    |  | M F    |              |
|   |                                    | - -                    |  | M F    |              |

| GENERAL INFORMATION               |  |                             |                      |
|-----------------------------------|--|-----------------------------|----------------------|
| # in Family _____                 | # of Children _____  | By age: 0-3 _____ 4-5 _____ | # in Household _____ |
| TANF : Yes No                     | SSI: Yes No  | WIC: Yes No                 | Food Stamps: Yes No  |
| Child Eligible Next Year: Yes No  | Does Child have a Suspected or Diagnosed Disability? If Yes please explain:<br>(If diagnosed, paperwork must be attached.) |                             |                      |
| Sibling Eligible Next Yr.: Yes No |  |                             |                      |

| HEALTH COVERAGE   |              |
|---|--------------|
| Medicaid Eligibility Status (circle one):<br><b>On Medicaid</b> <b>Not Eligible</b> <b>Potentially Eligible</b> | Medicaid #:  |
| Primary Health Coverage:  | Insurance #: |
| Other Health Coverage:  | Insurance #: |

**EMERGENCY CONTACTS & CHILD RELEASE INFORMATION**  
(If more space is needed use back of form)

|                  |         |     |            |              |                              |                                     |
|------------------|---------|-----|------------|--------------|------------------------------|-------------------------------------|
| <b>Contact 1</b> | Name    |     | Phone Type | Phone Number | <b>Relationship to Child</b> |                                     |
|                  | Address |     |            | ( )          |                              |                                     |
|                  | City    |     |            | ( )          |                              | <b>Emergency Contact?</b> Yes    No |
|                  | State   | Zip |            | ( )          |                              | <b>Release Child To?</b> Yes    No  |
| <b>Contact 2</b> | Name    |     | Phone Type | Phone Number | <b>Relationship to Child</b> |                                     |
|                  | Address |     |            | ( )          |                              |                                     |
|                  | City    |     |            | ( )          |                              | <b>Emergency Contact?</b> Yes    No |
|                  | State   | Zip |            | ( )          |                              | <b>Release Child To?</b> Yes    No  |
| <b>Contact 3</b> | Name    |     | Phone Type | Phone Number | <b>Relationship to Child</b> |                                     |
|                  | Address |     |            | ( )          |                              |                                     |
|                  | City    |     |            | ( )          |                              | <b>Emergency Contact?</b> Yes    No |
|                  | State   | Zip |            | ( )          |                              | <b>Release Child To?</b> Yes    No  |

|                     |         |      |       |     |              |
|---------------------|---------|------|-------|-----|--------------|
| <b>Doctor Name</b>  | Address | City | State | Zip | Phone<br>( ) |
| <b>Dentist Name</b> | Address | City | State | Zip | Phone<br>( ) |

**Certification:** I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Verifying Staff Member** \_\_\_\_\_ **Date** \_\_\_\_\_

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