1 Meadow Lane
Pittsfield MA 01201

Berkshire County Head Start
2018-2019 Application

Phone: 413-499-0137
Fax: 413-499-0186

* If you need assistance filling out this application or have questions, please call 413-445-4167 or 413-445-4162 *

Parent/Guardian's Name: _____ Date of Birth (DOB)_____
(Head of Household/ Person filling out this application) (*First, Middle & Last*)
Relationship to Eligible Child_____

Eligible Child's Full Name:_____DOB:_____Gender_____
(*First, Middle & Last*)

Child's place of birth _____ Child's SSN _____

Additional Parent/Guardian's Name: _____(*First, Middle & Last*)

DOB: _____Relationship to child_____

CONTACT INFORMATION

Address: _____
Street APT City ZIP CODE

Is your mailing address the same as your living address? **YES** **NO** If no, please list mailing address:

Address: _____
Street APT City ZIP CODE

Primary phone number_____

Cell phone _____

Work phone_____

Email: _____

Person(s) we can call if we cannot reach the parent / guardian listed above:

We must have working numbers to reach families!

Name_____

Number_____

CHILD DATA

Child's race _____ Is the child Latino or Hispanic? _____

- Was the child previously enrolled in Early/Head Start? YES NO
- Has the child previously applied or been on the waiting list? YES NO
- What is the Primary Language spoken at home? _____
- Child's ENGLISH FLUENCY? ☐ Not at all ☐ Not well ☐ Well ☐ Very Well
- Do you have any concerns about your child's health and development? YES NO

If yes, please describe:

- Does the child have an IFSP/IEP (or Disability)? YES NO

PLEASE CHECK ALL THAT APPLY:

- ☐ Active military deployment
- ☐ Family member smokes in the household
- ☐ Language spoken at home other than English
- ☐ Moved more than once in the last 12 months
- ☐ Parental developmental disability
- ☐ Poverty
- ☐ Suspected child abuse or neglect
- ☐ Biological mother < 17 years old
- ☐ Family social disorganization
- ☐ Maternal education < 8th grade
- ☐ Parent with less than a high school education
- ☐ Recent Immigrant to the United States
- ☐ Documented child abuse or neglect
- ☐ Parent(s) unemployed
- ☐ Parental substance abuse
- ☐ Serious Health Issue

Office use:
Date rec'd_____
CC_____
Promis_____
ERSEA_____

Is your family in the military?	YES	NO	Family member currently in Head Start?	YES	NO
Does a family member have a disability?	YES	NO	Are you teen mother?	YES	NO

Parent type: (check one)

- ☐ Two Parent family
- ☐ Single parent family(mother figure only) living with partner
- ☐ Single parent family (mother figure only)
- ☐ Single parent family(father figure only) living with partner
- ☐ Single parent family (father figure only)

Family type: (check one)

- ☐ Biological
- ☐ DCF Supportive (Two parent)
- ☐ DCF Supportive Slot (Foster)
- ☐ DCF Supportive Slot (Single)
- ☐ Foster Family
- ☐ Other family type
- ☐ Other relative(s)

Types of Services or Financial Assistance received:

- ☐ Child Care Subsidies
- ☐ Fuel Assistance
- ☐ Foster Care/Adoption Subsidy
- ☐ Public Housing Assistance
- ☐ Supplemental Security Income (SSI)
- ☐ WIC
- ☐ Child support/Alimony
- ☐ MassHealth
- ☐ Public Assistance/Welfare
- ☐ SNAP- Food Stamps
- ☐ Unemployment Insurance

Health Insurance: _____

Is your family HOMELESS? YES NO Have you been HOMELESS in the last 12 months? YES NO

(*For the purpose of this form, your family is considered homeless if you are living with others because of financial need*)

How did you hear about Head Start? _____

HOUSEHOLD FINANCES: Family employment and income information for the person(s) supporting the eligible child:

Number of adults in the household: _____ Number of children in the household: _____

Number of Adults contributing financially to the household: _____

PLEASE PROVIDE INCOME VERIFICATION AND STAFF WILL COMPLETE THE HIGHLIGHTED SECTION

Head of Household Name:	**Current Employer:**
Gross Amount:	**Frequency (circle one)** Weekly Bi-weekly 2x/month Monthly Annually

If you have no income, write "No Income" _____ and provide a letter explaining how you support yourself/family.

Statement of Parent/Guardian: I certify that information provided is correct to the best of my knowledge and is subject to verification. I am also aware that I may be subject to termination from the program if the information verified disqualifies me from eligibility. By signing this application I authorize Head Start to provide services: Vision, Blood Pressure, Hearing, Height and Weight, Speech and language, Development (fine motor, gross motor, cognitive/verbal) and to release my child's records to the local school system.

Signature _____ Date _____

Please List all HOUSEHOLD MEMBERS not listed on the front of this application:

Name: _____DOB_____SSN_____Gender_____Relationship_____

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Name: _____DOB_____SSN_____Gender_____Relationship_____

Name: _____DOB_____SSN_____Gender_____Relationship_____

Office Use Only:

Eligibility Determination Statement: I have examined the documents (checked) below and certify that the family is income-eligible in accordance with Head Start regulations and Eligibility-Selection-Enrollment-Attendance policies.

_____

Staff signature & date

Child Care Option

Berkshire County Head Start offers child care in Pittsfield and North Adams in addition to the half-day morning Head Start program that runs from 9:00 am - 12:30 pm. We can provide child care before and/or after the morning program. We also offer a full day/full year child care option as well. There are fees for child care. Parents who are income eligible for Head Start may be eligible to apply for a child care subsidy to help with child care costs if funding is available. (Please indicate if you need full day care or before and after Head Start Care and if you already have a childcare voucher.)

DO YOU NEED CHILD CARE? _____

DO YOU HAVE A CHILD CARE VOUCHER? Yes / No We can assist you in obtaining one