STEP, INC. HEAD START/EARLY HEAD START

Program Year: ___/___
Interview Date: ___/___/___
Enrollment Date: ___/___/___
ChildPlus Date: ___/___/___
CP/APP #: _____
Termination Date: ___/___/___

CHILD APPLICANT INFORMATION

Use Blue or Black Ink ONLY

☐ Head Start	☐ Early Head Start	☐ S2S Applicant	Date:

Child's Name (First, Middle, Last, Suffix)	**Nickname**	**DOB**	**Gender** □ Male □ Female	**SSN**

Child's Race
- □ Asian
- □ Black
- □ White
- □ American Indian/Alaskan Native
- □ Hawaiian/Pacific Islander
- □ Multi-Racial
- □ Other _____

Hispanic
- ☐ Yes
- ☐ No

English Proficiency
- □ None
- □ Little
- □ Moderate
- □ Proficient

Any Other Language?

Other Language Proficiency
- ☐ Poor
- ☐ Moderate
- ☐ Proficient

Primary Health Coverage
- □ Medicaid
- □ Private Insurance
- □ No Health Insurance
- □ Other

Medicaid Eligibility
- ☐ Not Eligible
- ☐ On Medicaid
- ☐ Potentially

Medicaid Number:

_____

Private Insurance Name:

_____

Policy ID:
Group Number: _____

Member ID: _____

911 Address

_____

House Number and Street /PO Box **City, VA** **Zip Code**

Mailing Address

_____

Parent/Guardian Name: _____

□ Cell □ Home □ Work □ Other

Phone Number: _____

Email: _____

Parent/Guardian Name: _____

□ Cell □ Home □ Work □ Other

Phone Number: _____

Email: _____

Current Day Care Provider: ☐ **Does Not Apply**

Name: _____ Address: _____

Previous Day Care Provider:

Name: _____ Address: _____

Is this child also enrolled in another childcare/school? □ Yes □ No

If yes, name of childcare/school: _____

Info: (check all that apply) □Food Stamps □ Access to Auto □TANF Recipient □ Homebound
Senatorial District: □ Franklin County: or □ Patrick County: (circle) 15 19 20 □ Other
House District: □Franklin County: or □ Patrick County: (circle) 9 14 16 □ Other
Home Heating Source: □ Electric □ Fuel/oil □ Kerosene □ LPG/propane □ Natural gas □ Solar energy □ Wood
Ever Experienced a Housing Crisis? □ Yes □ No **Benefit from Financial Counseling?** □ Yes □ No
Benefit from Parental Counseling? □ Yes □ No **Where did you hear about us?** _____
Would you like to be referred or receive information about other STEP programs? □ YES □ NO

Child's Name _____ DOB _____ Enrollment Date _____

#1 PARENT/GUARDIAN (HEAD OF HOUSEHOLD) INFORMATION - Custody: ☐ Yes ☐ No **Custody Order/Agreement**: ☐ Yes ☐ No

Relationship to Child: ☐ Biological/Adopted/Stepchild ☐ Foster ☐ Grandchild ☐ Other Relative ☐ Other

Check all that apply: ☐ Lives with family ☐ Provides financial support **Family Type:** ☐ Single Parent ☐ 2 Parent Household

Name (First, Middle, Last, Suffix)	**DOB**	**Gender** ☐ Male ☐ Female	**SSN**

Race □ Asian □ Black □ White □ American Indian/Alaskan Native □ Hawaiian/Pacific Islander □ Multi-Racial □ Other _____	**Hispanic** ☐ Yes ☐ No **English Proficiency** ☐ None ☐ Little ☐ Moderate ☐Proficient	**Other Language** _____ **Proficiency** ☐ Poor ☐ Moderate ☐ Proficient	**Health Insurance** ☐ Medicaid ☐ Private Insurance ☐ No Insurance ☐ Other

Highest Grade Completed □ Master's □ Grade 11 □ Bachelor's □ Grade 10 □ Associate's □ <Grade 9 □ College Degree/Training □ College or Advance Training □ GED □ HS Graduate □ Grade 12	**Employment Status** ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Full Time and Training ☐ Part Time &Training ☐ Training or School ☐ Retired or Disabled ☐ Unemployed	**Employer's Name** _____ **Employer's Address** _____ **Employer's Phone Number** _____

Primary Language at Home: ☐ English ☐ Spanish ☐ Other: _____	**Homeless Family** ☐ Yes ☐ No	**WIC** ☐ Yes ☐ No	**SSI** ☐ Yes ☐ No
Referred by Child Welfare Agency ☐ Yes ☐ No	**Veteran** ☐ Yes ☐ No	**Receiving Snap** ☐ Yes ☐ No	**TANF** ☐ Yes ☐ No

#2 ADULT LIVING IN HOUSEHOLD - Custody Order/Agreement: ☐ Yes ☐ No ☐ No additional adult in the household

Relationship to Child: ☐ Biological/Adopted/Stepchild ☐ Foster ☐ Grandchild ☐ Other Relative ☐ Other

Check all that apply: ☐ Lives with family ☐ Provides financial support

Name (First, Middle, Last, Suffix)	**DOB**	**Gender** ☐ Male ☐ Female	**SSN**

Race ☐ Asian ☐ Black ☐ White ☐ Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Multi-Racial	**Hispanic** ☐ Yes ☐ No **English Proficiency** ☐ None ☐ Little ☐ Moderate ☐ Proficient	**Other Language** _____ **Proficiency** ☐ Poor ☐ Moderate ☐ Proficient	**Veteran** ☐ Yes ☐ No	**Health Insurance** ☐ Medicaid ☐ Private Insurance ☐ No Insurance ☐ Other

Highest Grade Completed ☐ Master's ☐ Grade 11 ☐ Bachelor's ☐ Grade 10 ☐ Associate's ☐ <Grade 9 ☐ College Certificate/Training ☐ Advance Training ☐ GED ☐ HS Graduate ☐ Grade 12	**Employment Status** ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Full Time & Training ☐ Part Time & Training ☐ Training or School ☐ Retired or Disabled ☐ Unemployed	**Employer's Name** _____ **Employer's Address** _____ **Employer's Phone Number** _____

Child's Name _____ DOB _____ Enrollment Date _____

ADDITIONAL CHILD(REN) in the household ☐ **Check if NO ADDITIONAL CHILDREN**

Name (First, Middle, Last)	DOB	RACE	Gender (M/F)	GRADE
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

ADDITIONAL CHILD TO ENROLL: ☐ **Non-Applicable (check if this doesn't apply)**

☐ **Head Start**	☐ **Early Head Start**	☐ **S2S Applicant**	**Date:**

Name (First, Middle, Last)	**DOB**	**Gender** ☐ Male ☐ Female	**SSN**
Nickname:	**Currently In Child Care** □Yes □No		**Name of Current Provider:** **Name of Previous Provider:**
Race □ Asian □ American Indian /Alaskan Native □ Black □ White □ Hawaiian/Pacific Islander □ Multi-Racial □ Other:	**Hispanic** ☐ Yes ☐ No **English Proficiency** ☐ None ☐ Little ☐ Moderate ☐ Proficient		**Other Language** _____ **Other Language Proficiency** ☐ Poor ☐ Moderate ☐ Proficient
Primary Health Coverage □ Medicaid □ Private Insurance □ No Health Insurance □ Other **Other Coverage:** _____	**Medicaid Eligibility** ☐ Not Eligible ☐ On Medicaid ☐ Potentially **Medicaid Number:** _____		**Private Insurance Name:** _____ **Policy ID: Group Number:** _____ **Member ID:** _____
NOTES:			

Child's Name _____ DOB _____ Enrollment Date _____

STEP, INC. HEAD START PROGRAM INTAKE FORM

FAMILY CONCERNS – PLEASE CHECK ALL THAT APPLY.

(This information is confidential and will be used only in the application screening process.)

☐ A1 - Foster Care-*500* ☐ A2- SNAP-*500* ☐ A1 - Homeless-*500*	☐ A3-Returning HS or EHS -*500*	☐ B1 - Verified Disability of Child -*500* • Speech, developmental, etc. • (need documentation)
☐ B2 - Drug Dependency w/ Eligible Child	☐ B3 - History of Domestic Violence (child or family directed affected)	☐ B4 - Substance Abuse (child or family directly exposed)
☐ B5 - Mental Health Concerns of Individual or Direct Family Member (EX: depression, anxiety, etc.)	☐ B6 – Recent Separation/Divorce *(within the last 2 years)*	☐ B7 - Lack of Health Care Coverage (No Insurance)
☐ B8 - Postpartum Depression (currently)	☐ B9 - Loss of Employment/Financial Insecurity (little to no funds)	☐ B10 - Lack of Affordable Housing/ Housing Asst. Needed
☐ B11 - Chronic Illness (Individual or Direct Family member)	☐ B12 - Teen Parent (under age of 18) (currently)	☐ B13 - Lack GED or High School Diploma
☐ B14 – Grandparent/Kinship/Family Care	☐ B15 – Single Parent	☐ B16 – Military Service (parent or guardian, active or vet)
☐ B17 - Parent Concerns about applicant's behavior	☐ B18 – Receiving Medicaid	☐ B19 – Receiving WIC
☐ B20 – Food Insecurity (lack of food)	☐ B21 - Recent Death of Immediate Family or Household Member	☐ B22 - Sibling Currently Enrolled in EHS or HS
☐ B23 - In Job Training/College/GED	☐ B24- Lack of Reliable Transportation	☐ B25 - English as a Second Language
☐ B26 - More than 2 Children Under 5 yrs. or more than 4 in household.	☐ B27 - Lack of Affordable Childcare	☐ B28 - Physical/Social Isolation
☐ B29 - Incarcerated Immediate Family Member	☐ B30 - Overwhelmed by Raising Child(ren)	☐ B31-Family has moved more than twice in past 12 months.

READ AND SIGN BELOW

It is a federal offense to submit false information on this report and will result in immediate dismissal of this child from the STEP Head Start/Early Head Start Program. Your signature indicates that you have completed this application to the best of your ability and provided STEP Head Start/Early Head Start with accurate information.

PARENT SIGNATURE: **DATE:**

Do Not Write Below This Line! Office Use Only!

# of Family Members: ☐	Income Guidelines 100% $ _____ 130% $_____	Verified Annual Income $_____	☐ Income Eligible ☐ 100% ☐ 100-130% ☐ Over Income
☐ Income verification included	☐ Birth verification included	☐ Proof of Resident	☐ Interview completed

Early Head Start

A7. ☐ Infant _____
A7. ☐ Toddler _____

pts: _____

Head Start

A4. ☐ Transition EHS 3-year-old
A5. ☐ 4-year-old ___
A6. ☐ 3-year-old ___
☐ 5-year-old (document required) ___

pts: _____

Date of Application:	Screening Score:	Enrollment Date:
Date of Interview:	Program/County:	Classroom Assignment:
Date of Screening:	Program Year: **24/25**	Termination Date:

Updated Mar 2024