



Placer Community Action Council, Inc.  
 1166 High Street  
 Auburn, Ca 95603  
 530 885 - Kids  
 530 885 -5437  
 Fax 530 885 1902

## Early Head Start - Head Start – State Preschool Eligibility Application

### Family Information

#### Child Information

Child's Name: Last \_\_\_\_\_ First \_\_\_\_\_ Mi. \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Must attach copy of Official Birth Certificate Gender: M F (circle one)  
 SS#: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
 Secondary Language: \_\_\_\_\_ Ethnicity: \_\_\_\_\_  
 Dual Custody: Y \* N (circle one) Address: Street \_\_\_\_\_  
 Apt #: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Mailing Address: (if different): \_\_\_\_\_ City: \_\_\_\_\_  
 Zip \_\_\_\_\_ Homeless: Y \* N (Circle one) Phone (Home) (\_\_\_\_) \_\_\_\_\_  
 (Work) (\_\_\_\_) \_\_\_\_\_ (Message) (\_\_\_\_) \_\_\_\_\_  
 (Cellular) (\_\_\_\_) \_\_\_\_\_ (Email) \_\_\_\_\_

#### Adult Information

##### Father Information

Father/Guardian: Last: \_\_\_\_\_ First: \_\_\_\_\_ Mi: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ SS# \_\_\_\_\_ Marital Status: Married Single (Circle one)  
 Relationship to child: Natural Parent \* Step Parent \* Foster Parent \* Other \_\_\_\_\_ (circle one)  
 Ethnicity: \_\_\_\_\_ Primary Language: \_\_\_\_\_ Secondary Language \_\_\_\_\_  
 Living in the Home: Y \* N ( circle one) If no, Address: Street \_\_\_\_\_  
 City \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone (Home) (\_\_\_\_) \_\_\_\_\_ (Work) (\_\_\_\_) \_\_\_\_\_ (Message) (\_\_\_\_) \_\_\_\_\_  
 (Cellular) (\_\_\_\_) \_\_\_\_\_ (Email) \_\_\_\_\_

#### ERSEA Official Use Only:

Input Date:

Input By:

Assigned Center:

**Adult Information Continued:**

**Father Information**

**Income Information:**

Source of income/financial assistance: Wages \* TANF/AFDC \* Cal/Works \* Food Stamps

Unemployment \* SSI \* Foster Subsidy (This is the only income needed for children in foster care all other family income is uncountable) Child Support \* Alimony \* Disability (circle all that apply)

Child Support/Alimony paid out: \_\_\_\_\_ (attach documentation)

Employment Status: Working: Y \* N (circle one) Full Time \* Part Time \* Seasonal (circle one)

Gross Income: \_\_\_\_\_ Yearly \* Monthly (Circle One) Must attach verification for full month (pay stubs) or Tax Return for prior year. Recipients of TANF/AFDC, SSI, etc. programs must include award letter for income documentation Formerly on TANIF: Y N (circle one) Occupation: \_\_\_\_\_

Are you an Employee of PCAC: Y N (circle one) Is any Family Member an employee of PCAC: Y N

If so, What is the relationship: Mother Father Grandmother Grandfather Aunt Uncle Other \_\_\_\_\_

Education Level: Some High School Highest Grade Completed \_\_\_\_\_ GED \* High School Grad \* Some College \* Currently Attending College \* Other: Specify \_\_\_\_\_

**Mother Information**

Mother/Guardian: Last \_\_\_\_\_ First \_\_\_\_\_ Mi: \_\_\_\_\_

Birth Date: \_\_\_\_\_ SS#: \_\_\_\_\_ Marital Status: Married Single (Circle one)

Relationship to child: Natural Parent \* Step Parent \* Foster Parent \* Other \_\_\_\_\_ (circle one)

Pregnant: Y \* N (Circle one) Due Date: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Primary Language: \_\_\_\_\_ Secondary Language: \_\_\_\_\_

Living in the Home: Y \* N ( circle one) If no, Address: Street \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Phone (Home) (\_\_\_\_\_) \_\_\_\_\_ (Work) (\_\_\_\_\_) \_\_\_\_\_ (Message) (\_\_\_\_) \_\_\_\_\_

(Cellular) (\_\_\_\_\_) \_\_\_\_\_ (Email) \_\_\_\_\_

**Income Information:**

Source of income/financial assistance: Wages \* TANF/AFDC \* Cal/Works \* Food Stamps

Unemployment \* SSI \* Foster Subsidy (This is the only income needed for children in foster care all other family income is uncountable) Child Support \* Alimony \* Disability (circle all that apply)

Child Support/Alimony paid out: \_\_\_\_\_ (attach documentation)

Employment Status: Working: Y \* N (circle one) Full Time \* Part Time \* Seasonal (circle one)

**Adult Information Continued:**

**Mother Information Continued**

**Gross Income:** \_\_\_\_\_ **Yearly \* Monthly (Circle One)** Must attach verification for full month (pay stubs) or Tax Return for prior year. Recipients of TANF/AFDC, SSI, etc. programs must include award letter for income documentation

**Formerly on TANIF:** Y N (circle one) **Occupation:** \_\_\_\_\_

**Are you an Employee of PCAC:** Y N (circle one) **Is any Family Member an employee of PCAC:** Y N

**If so, What is the relationship:** Mother Father Grandmother Grandfather Aunt Uncle Other \_\_\_\_\_

**Education Level:** Some High School Highest Grade Completed \_\_\_\_\_ GED \* High School Grad

Some College \* Currently Attending College \* Other: Specify \_\_\_\_\_

**Household Information**

**Family Status:**

**Two Parent Family \* Single Parent Family \* Single Parent Family w/Partner (Circle one)**

**Number of Adults Living in the Home:** \_\_\_\_\_ **Number of Children Living in the Home** \_\_\_\_\_

**List names and birth dates of all children living in the home :**

**Name: Last** \_\_\_\_\_ **First** \_\_\_\_\_ **Birth Date** \_\_\_\_\_

**Name: Last** \_\_\_\_\_ **First** \_\_\_\_\_ **Birth Date** \_\_\_\_\_

**Name: Last** \_\_\_\_\_ **First** \_\_\_\_\_ **Birth Date** \_\_\_\_\_

**Name: Last** \_\_\_\_\_ **First** \_\_\_\_\_ **Birth Date** \_\_\_\_\_

**Health Information**

**Do you have health insurance :** Y N (circle one) **Do you need assistance with obtaining health**

**Insurance** Y N (circle one) **Insurance Provider:** Medi-cal \* Health Families \* Private Ins.

**Other:** \_\_\_\_\_ (circle one) **Provider Name:** \_\_\_\_\_

**Provider #** \_\_\_\_\_ **Do you have a primary care physician:** Y N (circle one)

**If no, Who provides health care for your child:** \_\_\_\_\_

**Physician Name:** \_\_\_\_\_ **Phone:** ( ) \_\_\_\_\_ **Fax( )** \_\_\_\_\_

**Address: Street** \_\_\_\_\_ **City** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Health Information Continued**

Date of your child's last physical exam: \_\_\_\_\_ (attach copy of records)

Are your child's Immunizations current: Y N (circle one) (attach copy of records)

(Immunizations must be current prior to attending program)

Do you have accessible dental care: Y N (circle one) Dentist Name: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_ Address: Street \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Date of your child's last Dental exam: \_\_\_\_\_ (attach copy of records)

Name of Dental Insurance: \_\_\_\_\_ Insurance #: \_\_\_\_\_

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**Childcare Information**

Does your child need full day/full year childcare due to working or going to school or training: Y N (circle one)

Is your child currently receiving childcare services: Y N (circle one)

If yes, from which category is child care services provided: Family Childcare Home \* Home of Relative \* Home of Unrelated Adult \* Public school/pre-kindergarten program \* Other ( please specify ) (circle one) Do you receive a childcare subsidy Y N (circle one)

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**Other Agency/Family Support Information (optional)**

Circle all of the other agencies and or support services you and your family are involved with:

Public Health Nursing \* Drug & Alcohol Program \* Child Protective Services \* Family Counseling Domestic Violence Coalition \* WIC \* Other: (Please specify) \_\_\_\_\_

**Special Situations**

**Health:**

Does your child have any serious or life threatening conditions: Y N (circle one)

If yes, please describe: \_\_\_\_\_

Does your child take any medications daily: Y N (circle one) Name any medications your child

**Special Situations Continued:**

will need to be given during program hours: \_\_\_\_\_

Does your child have any allergies: Y N (circle one)

**Special Situations Continued**

List all items your child is allergic too: \_\_\_\_\_

Briefly describe your child's allergy symptoms: \_\_\_\_\_

Name any health conditions your child has which may cause an emergency situation at school/socialization/childcare: \_\_\_\_\_

**Early Intervention/Special Education Services:**

**Children under three years old:**

Is your child receiving services from: ALTA Regional \* Infant Program \*

Other: (Please specify) \_\_\_\_\_

Does your family have an Individual Family Service Plan Y N (circle one) IFSP date \_\_\_/\_\_\_/\_\_\_\_\_

**Children three to four years old:**

Is your child receiving special education services Y N (circle one) Who is your child's service

Provider: \_\_\_\_\_ Does your child have an

Individual Education Plan (IEP) Y N (circle one) IEP Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

\* Please note you may be required to provided additional documents from your health care providers/special education providers prior to your child attending the program. In addition, a special written plan may need to be agreed upon prior to your child attending the program.

I certify the information I have provided is accurate to the best of my knowledge. I understand I must provide all eligibility documentation (Birth Certificate, Family Financial Documents) in order for my application to be processed. I acknowledge all my child's health records must be provided within 30 days after enrollment in order to continue participating in the program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_