



Head Start / Early Head Start  
 217 S. Salina Street  
 Syracuse, NY 13202  
 (315) 470-3346 / Fax: (315) 688-9840



**HEAD START/ EARLY HEAD START PROGRAM YEAR 2016 - 2017 APPLICATION**

\*PLEASE PRINT AND COMPLETE BOTH SIDES\*

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**\*\*ELIGIBLE CHILD INFORMATION\*\***

Name: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_  
Street Apt. # City State Zip Code

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Child's Race: \_\_\_\_\_

Child's Ethnicity: Hispanic \_\_\_ Non-Hispanic \_\_\_ Is English your first language? Yes \_\_\_ No \_\_\_

If no, what is your first language? \_\_\_\_\_ Will you need a translator? Yes \_\_\_ No \_\_\_

Program Option Applying For: Home Base \_\_\_ or Center-Base \_\_\_

Professionally diagnosed disability, special health/ dietary concern, or food allergy? Yes \_\_\_ No \_\_\_  
 If yes, please explain:

**MOTHER / GUARDIAN**

(Include Maiden Name if Applicable)

Name: \_\_\_\_\_

Address if different from above:  
 \_\_\_\_\_  
 \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Race: \_\_\_\_\_

Ethnicity: Hispanic \_\_\_ Non-Hispanic \_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ (home)  
 (\_\_\_\_) \_\_\_\_\_ (cell)

Are you the natural parent of the child? Yes \_\_\_ No \_\_\_  
 If no, what is your relationship? \_\_\_\_\_

**FATHER / GUARDIAN**

Name: \_\_\_\_\_

Address if different from above:  
 \_\_\_\_\_  
 \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Race: \_\_\_\_\_

Ethnicity: Hispanic \_\_\_ Non-Hispanic \_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ (home)  
 (\_\_\_\_) \_\_\_\_\_ (cell)

Are you the natural parent of the child? Yes \_\_\_ No \_\_\_  
 If no, what is your relationship? \_\_\_\_\_

Are you pregnant? Yes \_\_\_ No \_\_\_ Due Date: \_\_\_\_\_

If yes, are you interested in Early Head Start Home-Based Services for yourself? Yes \_\_\_ No \_\_\_

### ADDITIONAL HOUSEHOLD MEMBERS

Please provide the following information for all other household members. Attach additional sheets of paper, if necessary.

Last Name	First Name	Date of Birth	Sex (M/F)	Relationship to child	Race	Non-Hispanic
		/ /				
		/ /				
		/ /				
		/ /				
		/ /				
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		/ /				
		/ /				

**Total Household Members:** \_\_\_\_\_

**Additional information you feel will assist us to determine eligibility:**

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*The information requested is needed to help us establish your family's eligibility for the program. Please be advised this application is strictly confidential and voluntary. Any information regarding sex, education, or disability is gathered for statistical purposes only. This agency does not discriminate in any way in provision of services.*

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