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

PEACE Inc
EMPOWERING PEOPLE TO THRIVE | EST. 1968

HEAD START/ EARLY HEAD START PROGRAM APPLICATION

PLEASE PRINT AND COMPLETE BOTH SIDES

Application Will Be Good For One Year From Date - After One Year a New Application Will Be Necessary

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
		/ /				
		/ /				
		/ /				
		/ /				
		/ /				
		/ /				
		/ /				
		/ /				

Total Household Members: _____

Additional information you feel will assist us to determine eligibility:

_____

_____

_____

_____

_____

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