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 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.

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Parent / Guardian Signature