

**LUMBEE REGIONAL DEVELOPMENT ASSOCIATION, INC.
HEAD START / EARLY HEAD START
PROGRAM**

APPLICATION

CENTER _____ DATE _____
CHILD'S NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
AGE OF CHILD _____ BIRTHDATE _____
MALE _____ FEMALE _____ RACE _____
CHILD'S BIRTH CERTIFICATE NUMBER _____
CHILD'S SOCIAL SECURITY NUMBER _____

INFORMATION ABOUT THE FAMILY

FATHER'S NAME _____ SS # _____
ADDRESS _____ HOME PHONE _____
CITY _____ STATE _____ ZIP _____
WHERE EMPLOYED _____
WORK HOURS _____ BUSINESS PHONE _____

MOTHER'S NAME _____ SS # _____
ADDRESS _____ HOME PHONE _____
CITY _____ STATE _____ ZIP _____
WHERE EMPLOYED _____
WORK HOURS _____ BUSINESS PHONE _____

IF CHILD IS NOT LIVING IN THE HOME OF PARENTS, NAME OF RESPONSIBLE
ADULT

NAME _____ SS# _____

ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP _____

WHERE EMPLOYED _____

WORK HOURS _____ BUSINESS PHONE _____

ARE THERE OTHER AGENCIES OR SERVICES ASSISTING THE FAMILY?
DEPARTMENT OF SOCIAL SERVICES, SOCIAL SECURITY, ETC.

PLEASE LIST THE CASE NUMBER OF EACH:

SSI# : _____ TANF #: _____ FOOD STAMP#: _____

MEDICAID #: _____ WIC #: _____

DOES FAMILY HAVE HOSPITAL INSURANCE ON CHILD? YES ___ NO ___

NAME IOF INSURANCE COMPANY _____

POLICY # _____

WILL THE CHILD NEED TRANSPORT TO THE CENTER?

YES ___ NO ___

DOES THE CHILD LIVE WITHIN A FIVE-MILE RADIUS OF THE CENTER?

YES ___ NO ___

WHAT ARE THE DIRECTIONS TO YOUR HOME FROM THE CENTER?

EMERGENCY INFORMATION

IF NEITHER FATHER, MOTHER, OR GUARDIAN CAN BE CONTACTED, CALL:

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

MARITAL STATUS: SINGLE _____ MARRIED _____

SEPARATED _____ WIDOWED _____

OF ADULTS IN HOME _____ RELATIONSHIP TO CHILD _____

NAMES OF OTHER CHILDREN IN THE HOME

AGE

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MEDICAL HISTORY

IS CHILD ALLERGIC TO ANYTHING: YES _____ NO _____

WHAT _____

IS CHILD UNDER A DOCTORS CARE YES _____ NO _____

IF YES, WHY? _____

OTHER INFORMATION

INFORMATION CONCERNING THE CHILD THAT WILL BE HELPFUL IN HIS/HER EXPERIENCE IN GROUP ACTIVITIES SUCH AS PLAY, EATING, SLEEPING HABITS, FEARS, LIKES, AND DISLIKES, ETC.

CHILD'S MEDICAL INFORMATION

1. Is child allergic to anything? Yes _____ No _____

Please describe _____

2. Is child currently under a doctor's care? Yes _____ No _____

If yes, why _____

3. Is the child on any continuous medication? Yes _____ No _____

Name of medication _____

4. Any previous hospitalization or operations? Yes _____ No _____

If yes, what _____

5. Any history of significant previous diseases or recurrent illness?

Yes _____ No _____ Diabetes: Yes _____ No _____

Convulsions: Yes _____ No _____ Heart Trouble: Yes _____ No _____

Other, what? _____

6. Does the child have any physical disabilities: Yes _____ No _____

Any mental disabilities? Yes _____ No _____

Please describe _____

Parent / Guardian _____

INCOME VERIFICATION DOCUMENTATION FORM

CERTIFICATION OF VERIFICATION

I certify that I have examined the following income documentation of:

Family Name: _____

CHECK ALL THAT APPLY

- _____ Income tax form 1040 or 1040A
- _____ Social Security
- _____ W-2 Form
- _____ Unemployment Compensation
- _____ Pay Stubs
- _____ Verified by Employer
- _____ Pay Envelopes
- _____ Veterans Benefits
- _____ Foster Care Assistance
- _____ Notification of Child Support
- _____ Notification of Public Assistance (TANF)
- _____ Other

Total Annual Income \$ _____

Staff Signature _____ Date _____

Parent / Guardian _____ Date _____