

Please check any issues which have occurred within your child's immediate family:

Child Abuse or Neglect	<input type="checkbox"/>	Incarceration of Parent	<input type="checkbox"/>
Child Raised by Grandparent/Other Relative	<input type="checkbox"/>	Military Deployment	<input type="checkbox"/>
Death in Family	<input type="checkbox"/>	Parent(s) Less than HS/GED	<input type="checkbox"/>
Diagnosed Health Concern/Child	<input type="checkbox"/>	Parent in School	<input type="checkbox"/>
Diagnosed Health Concern/Parent	<input type="checkbox"/>	Referred by Community Agency	<input type="checkbox"/>
Drug or Alcohol Abuse	<input type="checkbox"/>	Single Parent	<input type="checkbox"/>
Divorce	<input type="checkbox"/>	Teen Parent	<input type="checkbox"/>
Domestic Violence	<input type="checkbox"/>	Unemployed	<input type="checkbox"/>

Additional Information/Circumstances:

Is someone in your family receiving SSI benefits?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you receive OWF benefits?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your family homeless?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is this application for a foster child?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your child have a diagnosed disability/IEP?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

What School District do you reside in?

Where or how did you hear about the Head Start program?

Please complete the next page. Your application cannot be processed without this information:

- Check all sources of income
- List all family members
- Tell us if you have immediate needs

For our purposes, a person is considered a member of your family if they are supported by the income of the parent or guardian of the child enrolling in the program and are related to the parent or guardian by blood, marriage or adoption.

Next Steps: The Enrollment Process

- When your child's application is approved, you will receive an acceptance letter and a physical and dental form for your child. You must have these forms completed and returned with your child's enrollment paperwork.
- A Family Advocate will deliver the enrollment paperwork to your home and schedule an appointment with you to review your paperwork and your completed physical and dental forms.
- You will also need to bring your child's shot record and medical card to this appointment.

Community Action Agency of Columbiana is an equal opportunity provider.

Today you are applying for : **HEAD START**

*This form is to be filled out by the individual requesting the service every time they request it.

**Please put the primary parent information on the top part of this form, and all others living in your home including the child you wish to receive services listed under household members.

CAA Intake Form

SS

#	Last Name	First Name
DOB	Address	
City	Zip Code	Telephone Number

Gender		Disabled		Ethnicity					
<input type="checkbox"/>	Female	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Black	<input type="checkbox"/>	Hispanic	<input type="checkbox"/>	Asian
<input type="checkbox"/>	Male	<input type="checkbox"/>	No	<input type="checkbox"/>	Native Am	<input type="checkbox"/>	White	<input type="checkbox"/>	Other

Education			Food Stamps	Health Insurance					
<input type="checkbox"/>	0-8	<input type="checkbox"/>		12+	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Self-Ins	
<input type="checkbox"/>	9-12 Non-Grad	<input type="checkbox"/>	Unknown	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	None
<input type="checkbox"/>	HS Grad/GED	<input type="checkbox"/>	Coll Grad	<input type="checkbox"/>	No	<input type="checkbox"/>	Private	<input type="checkbox"/>	Unknown

Veteran		# in Household	Family Type				
<input type="checkbox"/>	Yes		<input type="checkbox"/>	F Single Par	<input type="checkbox"/>	Two Parent	<input type="checkbox"/>
<input type="checkbox"/>	No	<input type="checkbox"/>	M Single Par	<input type="checkbox"/>	Single	<input type="checkbox"/>	Other

Housing		Farmer		Client Income			
<input type="checkbox"/>	Own	<input type="checkbox"/>	Farmer	<input type="checkbox"/>	Weekly	<input type="checkbox"/>	Annual
<input type="checkbox"/>	Rent	<input type="checkbox"/>	Migrant	<input type="checkbox"/>	Bi-Weekly	<input type="checkbox"/>	13 Weeks
<input type="checkbox"/>	Other	<input type="checkbox"/>	Seasonal	<input type="checkbox"/>	Monthly	Gross Amount:	

Sources of Income									
<input type="checkbox"/>	Child Support	<input type="checkbox"/>	Self Employment	<input type="checkbox"/>	No Income	<input type="checkbox"/>	Worker's Comp.	<input type="checkbox"/>	Utility Assist
<input type="checkbox"/>	Wages	<input type="checkbox"/>	Social Security	<input type="checkbox"/>	Disability Assist	<input type="checkbox"/>	Pensions	<input type="checkbox"/>	Other
<input type="checkbox"/>	Unemployment	<input type="checkbox"/>	TANF/OWF	<input type="checkbox"/>	SSI/SSD	<input type="checkbox"/>	Emp. Disability	<input type="checkbox"/>	VA Disability

Household Members - Use an additional sheet of paper if needed.				
SS#				
Last Name				
First Name				
Date of Birth				
Gender				
Disabled				
Ethnicity				
Education				
Health Insurance				
Veteran				
Income Frequency				
Gross Amount				
Source of Income				

I certify that this statement is true and correct to the best of my knowledge, and authorize the release of any and all information necessary for verification purposes.

Signature of Client

Date

