



Early Head Start
Application for Enrollment
Serving Pregnant Women, Infants and Toddlers up to age 3

I am applying for:

Home Visiting Program (weekly visits)
 Center-Based
 First Available (Home Visiting or Center-Based)

Adult Name: _____
First MI Last Date of Birth Other

Address: _____
Street Apt. # P.O. Box

_____ City State Zip County

_____ Phone 1 Phone 2 E-mail address

This address is: House/Apartment Friend/Relative's House Motel/Shelter/Temporary Housing

Primary Language: English Spanish Other: _____

Were you under 20 years old when your first child was born? Yes No

Are you currently pregnant? Yes No If yes, due date: _____

Were you referred by local agency (CPS, Foster care, WIC)? Yes No If yes, by whom: _____

Family Income Information: Eligibility is based on child's age, family income, child's need, and available openings.

	Total Gross Income	Time Period of Total Income		Source of Income (check all that apply)		
Parent 1	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-weekly	<input type="checkbox"/> Working	<input type="checkbox"/> Child Support	<input type="checkbox"/> DHHS Financial
		<input type="checkbox"/> Monthly	<input type="checkbox"/> Annually	<input type="checkbox"/> SSI	<input type="checkbox"/> Other: _____	
Parent 2	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-weekly	<input type="checkbox"/> Working	<input type="checkbox"/> Child Support	<input type="checkbox"/> DHHS Financial
		<input type="checkbox"/> Monthly	<input type="checkbox"/> Annually	<input type="checkbox"/> SSI	<input type="checkbox"/> Other: _____	

Child 1 Name: _____
First MI Last Date of Birth Male Female

Child 2 Name: _____
First MI Last Date of Birth Male Female

Do any of the above children have a special need (IFSP) or a home visitor (Early On, health care visitor)? Yes No If yes, which child: _____
 Worker Name/Agency: _____

Other Family Members Living in Home:

Name	Date of Birth	Relationship to Child(ren)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Make additional notes regarding recent income changes, family size, or other concerns on the back of application.

I certify that the above information is correct and true to the best of my knowledge. I authorize the release of this information and educational records to be shared between EightCAP, Inc. 0-5 Head Start and any Intermediate School District.

Signature: _____ **Date:** _____

Return application to: Early Head Start 5827 Orleans Rd, Orleans, MI 48865 **Apply online:** www.8cap.org
 Fax: 616-754-9310 Email: deniseb@8cap.org Phone: 616-754-9315, option 2

State & Federally funded programs will not discriminate against anyone because of race, color, national origin, sex, age or disability.

FOR OFFICE USE ONLY

Oct 2021 ab/ja	Original-Central Office file	Reviewed by _____	Date _____	Inc. _____	Age _____
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