



375 Lake Blvd., Ste. #100
530-241-1036; Fax 530-241-2703

PY_____ APPLICATION FOR SERVICES

Check ALL that Apply: ☐ New ☐ Update WL ☐ Baby of Prenatal Mother
Joint/Split Custody Family: ☐ Guardian/Family 1 ☐ Guardian/ Family 2
☐ WL Family Site Change: _____
☐ Mid-year Transfer to Site: _____

A1. APPLICANT (CHILD OR PREGNANT MOTHER) APPLYING FOR SERVICES *Legal Names only

First Name	Middle Name	Last Name	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Applicant's Primary Language IF NOT English: <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____			Preg. Mom Due Date: _____	

A2.PARENT/GUARDIAN: * Legal Names only

<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Foster	Name: _____	Date of Birth: _____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
EMPLOYMENT STATUS: <input type="checkbox"/> Student <input type="checkbox"/> Homemaker <input type="checkbox"/> Unemployed (w/ benefits) <input type="checkbox"/> Unemployed (no benefits) <input type="checkbox"/> Employed (PT/FT) <input type="checkbox"/> Self-Employed <input type="checkbox"/> Seasonally Employed: # months? _____ <input type="checkbox"/> Retired <input type="checkbox"/> Disabled			
Parent work/need schedule (State/Collabs only): 1.Mon _____ Tues _____ Wed _____ Thur _____ Fri _____ Sat _____ Sun _____			
<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Foster	Name: _____	Date of Birth _____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
EMPLOYMENT STATUS: <input type="checkbox"/> Student <input type="checkbox"/> Homemaker <input type="checkbox"/> Unemployed (w/ benefits) <input type="checkbox"/> Unemployed (no benefits) <input type="checkbox"/> Employed (PT/FT) <input type="checkbox"/> Self-Employed <input type="checkbox"/> Seasonally Employed: # months? _____ <input type="checkbox"/> Retired <input type="checkbox"/> Disabled			
Parent work/need schedule (State/Collabs only): 1.Mon _____ Tues _____ Wed _____ Thur _____ Fri _____ Sat _____ Sun _____			

A3. FAMILY ADDRESS:

Living Address	Address Line 2	Zip	City	State
County of Residence: <input type="checkbox"/> Shasta <input type="checkbox"/> Trinity <input type="checkbox"/> Siskiyou <input type="checkbox"/> Other _____				
Mailing Address (If Different)	Address Line 2	Zip	City	State
Contact/Primary Phone #:	Type (Check One) <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work _____	Alternative Phone #:	Type (Check One) <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work _____	
E-Mail Address: 1: _____ 2: _____				

A4. JOINT/SPLIT CUSTODY FAMILIES only: Court papers required & Complete Application, Eligibility Form & documents must be completed by the other family sharing custody.
* SKIP if you receive TANF/CalWORKS.

Child Name: _____

B1. ADDITIONAL SELECTION CRITERIA

☐ 5 Year Old: Kindergarten Unavailable

B2. PROGRAM SELECTION & NEED FOR CARE (See Reference Card For Program Options)

PLEASE CIRCLE ONE OF EACH:

EHS or HS; Home Base / Center Base / Family Child Care; Full-Day or Part-Day HB Ok? ☐ YES ☐ NO
Site Name: _____ EHS Only

STUDENTS:

College: _____ ☐ Currently enrolled: # units _____, ☐ Day classes ☐ Night classes On Campus: Y/N

☐ Teen enrolled in High School on-campus: Name of school _____

☐ Teen enrolled in Independent Study: Name of School District reside in: _____

SCOE & STATE COLLABORATIONS NEED FOR CARE:

ALL Parent/Guardians *unable* to provide care *during* center hours due to: ☐ Work ☐ School

☐ Seeking Employment ☐ Parental Incapacity ☐ Other: _____

B3. OTHER CIRCUMSTANCES

CHECK ALL THAT APPLY:

☐ Related to SHS Staff Name: _____

☐ Currently receiving SHS services: Other Child Name: _____ Site: _____

B4. RESOURCES PROVIDED & NOTES

- ☐ 211 Card
- ☐ Key Services
- ☐ Housing List

- ☐ Triple P Flyer
- ☐ Parent Café Flyer
- ☐ Other: _____

Additional Notes/ Clarifications/Special Circumstances:

Signature of Head Start Staff

Date Signed

Printed Name:



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Document Request / Documento Adicional

Parent Name/Nombre del Padre: _____ Date/Fecha: _____

Child Name/Nombre del Niño: _____

DOB/Fecha de Nacimiento: _____

Date Needed By / Fecha Requerida Para: _____

Attention / Atención: _____

Documents Requested / Documentos Adicionales Necesarios:

Age verification document:

Parent Signature/Firma del Padre: _____ Date/Fecha: _____

**Please return items by DocuSign, to Administration office or the nearest Head Start Center / Por favor regresar esta información a la Oficina Administrativa o al Centro de Head Start más cercano.*

**Please include this form with your documents / Por favor incluir este formulario con sus documentos.*

**If items are not received by the date above, a new application appointment will need to be made. / Si los documentos no son recibidos en la fecha de arriba, una cita para llenar una nueva solicitud será necesaria.*

Staff Only: Scan to ERSEA Date Received/Scanned _____