

Terrebonne Parish Consolidated Government Head Start Program

Head Start is a federally funded comprehensive preschool program for children ages 3 to 5 from low income families. In order to qualify for the 2018-2019 school session, a child must be three years old by September 30, 2018.

The Terrebonne Parish Head Start Program does not discriminate on the basis of race, color, national origin, sex, or disabilities.

Children do not have to be potty trained for acceptance in Head Start.

Parents of children with severe or multiple disabilities are encouraged to apply.

There is no fee charged for Head Start services. Parents must provide transportation.

To process this application, copies of the following information must be provided. *The information you provide on and with this application will remain confidential.*

- | | |
|---|--|
| <input type="checkbox"/> Child's Birth Certificate | <input type="checkbox"/> Child's Immunization Records |
| <input type="checkbox"/> Child's Social Security Card | <input type="checkbox"/> Child's Medicaid/Ins. Card |
| <input type="checkbox"/> Parent/Guardian's Drivers License/ID | <input type="checkbox"/> Proof of Residency (utility bill) |

Verification of Income- If you are employed, you must provide two current check stubs. If you receive food stamps, you must provide a food stamp printout sheet dated within the last 30 days. If you receive child support, SSI or unemployment compensation, you must provide proof that you receive these.

Child's Evaluation/Individual Education Plan (If your child receives speech therapy, physical therapy, occupational therapy, or Early Steps Services)

Send signed/dated application and copies of the documents listed above to:

**Terrebonne Parish Head Start
809 Barrow Street
Houma, Louisiana 70360
Attention: Araminta "Sue" Rainey**

Check any services your child is currently receiving:

- Private therapy (speech, physical, or occupational therapy)
- Home-based services through the Terrebonne Parish School System
- Private day care
- Early Steps

Where did you hear about the Head Start Program? Newspaper Flyer
 Relative/Friend School System Other _____

**If you have questions or need assistance with the application process,
please call (985) 580-7273.**

**TERREBONNE PARISH HEAD START
2018-2019 SCHOOL YEAR APPLICATION**

All sections must be completed in order for this application to be processed. This application must be completed, signed and dated by the PARENT or LEGAL GUARDIAN ONLY.

CHILD'S NAME: _____
 First Name **Middle Initial** **Last Name**

CHILD'S DATE OF BIRTH: ____ / ____ / ____

CHILD'S SOCIAL SECURITY NUMBER: ____ - ____ - ____

ADDRESS WHERE CHILD LIVES:

Street **City** **Zip Code**

MAILING ADDRESS (IF DIFFERENT FROM LIVING ADDRESS)

PO Box or Street Address **City** **Zip Code**

TELEPHONE NUMBER(S): _____

ALTERNATE TELEPHONE NUMBER(S): _____

E-Mail Address: _____

CHILD'S GENDER: ____ **Female** ____ **Male**

CHILD'S RACE: ____ **Asian** ____ **African American** ____ **Native American**
 ____ **White** ____ **Other (List: _____)**

CHILD'S ETHNICITY: ____ **Hispanic or Latino** ____ **Non-Hispanic or Latino**

PRIMARY LANGUAGE SPOKEN BY CHILD: _____

PRIMARY LANGUAGE SPOKEN IN THE HOME: _____

FAMILY TYPE (check only one):

- ____ **Married**
- ____ **Single (Mother Only)** ____ **Single (Father Only)** ____ **Teen Parent**
- ____ **Grandparents-Custodial (must provide documentation)**
- ____ **Other Relatives-Custodial (must provide documentation)**
- ____ **Foster Parent (must provide documentation)**

_____ TOTAL NUMBER OF PERSONS THAT LIVE IN THE HOUSEHOLD Count only those that are supported by the income of the parent or legal guardian.

You must list these household members, their date of birth and relationship to the child you are applying for including yourself.

First and Last Name	D.O.B.	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MOTHER/GUARDIAN'S INFORMATION

Name: _____ **Date of Birth:** _____
Social Security Number: _____ **Telephone:** _____
Level of Education:
_____ **Received High School Diploma/GED** or **Last Grade Completed** _____
_____ **Some College** _____ **College Graduate (Degree** _____ **)**
_____ **Currently Enrolled in High School /Technical Training School/College**

Is Mother/Guardian currently employed? _____ **Yes** _____ **No**
Where? _____ **Work number:** _____
_____ **Full Time** _____ **Part Time** _____ **Paid** _____ **Weekly** _____ **Bi-Weekly** _____ **Monthly**

FATHER/GUARDIAN'S INFORMATION

Name: _____ **Date of Birth:** _____
Social Security Number: _____ **Telephone:** _____
Level of Education:
_____ **Received High School Diploma/GED** or **Last grade Completed** _____
_____ **Some College** _____ **College Graduate (Degree** _____ **)**
_____ **Currently Enrolled in High School/Technical Training School/College**

Is Father/Guardian currently employed? _____ **Yes** _____ **No**
Where? _____ **Work Number:** _____
_____ **Full Time** _____ **Part Time** _____ **Paid** _____ **Weekly** _____ **Bi-Weekly** _____ **Monthly**

Does your child receive Medicaid/LaChip? _____ No _____ Yes
 Do you receive Food Stamps? _____ No _____ Yes
 Do you receive FITAP/TANF (Welfare)? _____ No _____ Yes
 Do you receive child support? _____ No _____ Yes
 Do you receive Social Security Benefits? _____ No _____ Yes
 Do you receive S.S.I.? _____ No _____ Yes
 Do you receive Unemployment Comp.? _____ No _____ Yes

Do you have reliable transportation to bring your child to and from Head Start?
 _____ Yes _____ No (Head Start does not provide transportation.)

At what school will your child attend Pre-K/Kindergarten? _____

Have you ever had a child in Head Start before? _____ Yes _____ No
 If yes, give child's name, where and year of enrollment: _____

Does the child you are applying for have a diagnosed disability or a condition that
 may lead to a disability? _____ No _____ Yes
 If yes, describe and attach I.E.P. from School Board: _____

Is your child on a special diet or take medication(s) prescribed by a physician?
 _____ No _____ Yes If yes, please list details: _____

Is there anything else you would like for us to know about your child or family (i.e.,
 homeless, displaced by natural disaster, sudden loss of income, terminally ill family
 member, or other type of family crisis)? _____

Please identify any assistance/resources your family may need (check all that apply).
 Housing Food Stamps Medicaid/LACHIP/Health Insurance
 Transportation Family Counseling GED/Continuing Education
 Utility Assistance Employment Legal Aid Mental Health SSI
 Other (please list) _____

I certify that all the information I have provided on and with this application, including income, is accurate.

Parent/Guardian Signature

Date

TPCG Head Start Staff Representative

Date