Alameda Head Start & Early Head Start
2325 Clement Avenue, Suite A, Alameda, CA 94501
Tel: (510) 629-6350    Fax: (510) 865-1930

APPLICATION INFORMATION

Alameda Head Start/Early Head Start offers comprehensive child development, health and family services to qualified pregnant women, children from birth to five and their families.

For us to determine your family’s eligibility for services, you must first complete and submit the attached application (one per household) and provide copies of the required documentation as listed:

Submit the following for each household:

☐ DOCUMENTATION OF HOUSEHOLD INCOME
   (Provide copies of all of the following that apply.)
   _____ Notice of Action (TANF letter showing amount of benefit)
   _____ SSI Eligibility Notification
   _____ W2 Form OR Income Tax Return (most recent / first page)
   _____ Child’s Income (only for foster parents)
   _____ Child Support Payments
   _____ Most recent pay stub, year to date income, unemployment check, support check, personnel letter from your employer, etc.

Submit the following for each applicant:

☐ PROOF OF AGE (Provide copy of at least one of the following documents.)
   _____ Birth Certificate     _______ Passport     _____ Medi-Cal Card (if applicable)

☐ IMMUNIZATION RECORD (Provide copy of both front and back.)
   _____ Immunization Record

Once your application packet is received, it will be reviewed, assessed and verified by the Alameda Head Start/Early Head Start Enrollment Office. Notification of your family’s eligibility will be sent to you within three weeks of the receipt of your complete application packet.

Prior to placement we must ensure compliance with federal regulations and therefore immediate placements are not available.

When an opening is available all eligible families will be assessed and placements made in accordance with our Selection & Placement Criteria.

If you need any assistance completing this application or have any questions, please feel free to contact the Enrollment Office.

Sincerely,

AHS/EHS Enrollment Office
2325 Clement Avenue, Alameda, CA 94501
Phone: (510) 629-6356
Fax: (510) 865-1930
ALAMEDA FAMILY SERVICES - HEAD START/EARLY HEAD START
2325 CLEMENT AVE., SUITE A, ALAMEDA, CA 94501 ☏ (510) 629-6350 ✉️(510) 865-1930

APPLICATION FOR ENROLLMENT

Pregnancy to Pre-K (Ages 0 - 5) within the City of Alameda

**APPLICANT(S)**

<table>
<thead>
<tr>
<th>Child's Name: __________________________________________</th>
<th>Male</th>
<th>Female</th>
<th>DOB: __________________</th>
<th>EHS</th>
<th>HS</th>
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<tr>
<td>□ Hispanic</td>
<td>□ Non-Hispanic</td>
<td>AND</td>
<td>□ White</td>
<td>□ Black</td>
<td>□ Asian</td>
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**GUARDIANSHIP & EMPLOYMENT**

Parental Status:  □ Single  □ Two Parent  □ Foster  □ Non-Parent Guardianship  □ Joint/Shared Custody

Parent/Guardian-Primary Contact (AO1):

Last Name: ____________________________________________ | First Name: __________________________________________

Birth Date: ____/____/____  □ Male  □ Female  Primary Language: _________________________

Last Grade Completed: __________________ | Graduated: □ High School  □ College  □ Head of Household

__________________________________________  □ Part Time  □ Full Time  □ Unemployed

Occupation / School

Parent/Guardian (AO2):

Last Name: ____________________________________________ | First Name: __________________________________________

Birth Date: ____/____/____  □ Male  □ Female  Primary Language: _________________________

Last Grade Completed: __________________ | Graduated: □ High School  □ College  □ Head of Household

__________________________________________  □ Part Time  □ Full Time  □ Unemployed

Occupation / School

**RESIDENCY**

Housing:  □ Homeless  □ Alameda Point Resident  □ Midway Shelter  □ Shared Housing  □ Public  □ Rent  □ Own

Primary Residence: __________________________________________ | Street & Apartment #: __________________ | Alameda, CA | Zip Code: __________________

Mailing / Other Address: ______________________________________

Home: ( ) ___________________ | Cell/Work: ( ) ___________________ | Other: ( ) ___________________

Email: ________________________________________________________
HOUSEHOLD

Total number of family members living in the same household as the applicant(s) who are financially supported by, and related by blood, marriage or adoption to the parent/guardian(s) listed above: ________

List family member(s) who were included in the number reported above, but not already listed in this application:

<table>
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<tr>
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<th>Age</th>
<th>Relationship</th>
<th>Gender</th>
<th>Occupation</th>
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INCOME

Does any family member living in the household receive benefits from TANF, SSI or Cal-Works? ☐ Yes ☐ No

If yes, who and what type of benefit? ____________________________

Total household’s income over the last 12 months? $ ____________________________

If zero, how is the family being supported financially? ____________________________

ADDITIONAL FACTORS

Does any member of your household have a diagnosed disability or have other special needs? ☐ No ☐ Yes

If yes, name(s): ________________________________________________________

Diagnosis/Condition: ____________________________ ☐ IEP ☐ IFSP

Receiving treatment and/or services from: ____________________________

Is or was any applicant listed enrolled in Head Start or Early Head Start? ☐ No ☐ Yes Year(s): ______________

If yes, name(s): ____________________________ Location(s): ____________________________

Are there any family circumstances that warrant additional placement consideration, such as death, divorce, mental health issues, serious medical conditions, incarceration, domestic violence, substance abuse, child abuse? ☐ No ☐ Yes

If yes, explain briefly: ________________________________________________________

CERTIFICATION

Documentation of proof of birth and household income must be submitted with this application. Documentation may include any of the following: Notice of Action, W2, Tax Return (first page), recent pay stub, year-to-date income, child support, unemployment, letter from employer or signed statement of no-income. Verification of income will be conducted by Alameda Head Start prior to acceptance into any program option. Documentation of work and/or school schedule for each adult member of the household will be required for households seeking placement in center-based options offering more that part-day services. A copy of an applicant’s signed IEP or IFSP must be submitted for priority placement consideration.

Name of person completing application if not the child’s legal guardian: ____________________________

Relationship to the child/family: ____________________________ Phone ( ) ______________

I hereby certify by this signature that the information presented in this application is true and correct.

Parent/Guardian’s Signature ____________________________ Date ______________