ST. CROIX TRIBAL HEAD START - APPLICATION - PART I

Family Adult Name	DOB	Family Adult Name	DOB

Enrolled Child _____ DOB _____ ☐ HS ☐ State Slot

Enrolled Child _____ DOB _____ ☐ HS ☐ State Slot

Enrolled Child _____ DOB _____ ☐ HS ☐ State Slot

Living Address - Street:			City:
State:	Zip:	County:	E-Mail Address:

Mailing Address (if different)

Phone # _____ ☐ Home ☐ Cell ☐ Message ☐ Work	Phone # _____ ☐ Home ☐ Cell ☐ Message ☐ Work	Text ☐ Yes ☐ No	E-Mail ☐ Yes ☐ No

# in Family _____	Selection Points _____	# of Eligible Children _____	Preferred method of Contact ☐ Phone ☐ Text ☐ Email	Estimated Amount $_____

TANF	Homeless	SSI	Foster	WIC	Food Share / SNAP	Active Military
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

***Income to be calculated back 12 months from the date of application or the full calendar year prior to the date of application. Once verified as income eligible children remain income eligible until moving from EHS to HS. Head Start remain eligible for two years.**

FAMILY INCOME VERIFICATION

☐ Categorically Eligibility ☐ I.E. ☐ 130% ☐ OI ☐ Last Year Verified ☐ Previously Verified

Family Member	Source	Amount	Per: Yr. Mo, Wk	Verified (see codes below)	Annual Amount
		$	X		$
		$	X		$
		$	X		$

Total Yearly $

VERIFIED CODES:

BS – Bank Statement
CS – Check Stub
EL –Employer Letter
IJF – Income Justification Form
SS – Social Security
SSI – Supplemental Security (Not SSDI)
TAN – TANF Statement
W2 – W2 or Taxes

I certify that this information is true. If any part is false, my participation in this agency's program may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence with the agency and is accessible to me during normal business hours.

Parent/Guardian Signature _____ Date _____

Verifying Staff Signature _____ Date _____

☐ **Refer to Sibling's** _____ **Application Part 2 for information**

Sibling's name

Health Coverage

Medicaid (Forward Card)	Forward Card #	**Forward Card**
☐ Enrolled ☐ Eligible ☐ Not		☐ Yes ☐ No

☐ Tribal Health Ins ☐ Private Health Ins ☐ Private Dental Ins	☐ No Medical Ins ☐ No Dental Ins ☐ Referred to local clinic	Name of Insurance Company: Name of HMO: Name of Dental Insurance:

Medical Clinic:	Dental Clinic:
Address:	Address:
Phone:	Phone:

Race (Check all that apply):		
☐ Black or African American ☐ White/Hispanic	☐ American Indian or Alaska Native ☐ Biracial/Multiracial: 2 or more races ☐ Other:	☐ Asian ☐ Native Hawaiian or Pacific Islander
Ethnicity: ☐ Hispanic or Latin Origin ☐ Non Hispanic/Non-Latino Origin	School District/Elementary School:	
Eligible Next Year: ☐ Yes ☐ No	Sibling Eligible Next Year: ☐ Yes ☐ No	Selection Points:

CODES:

Education Level - EL

G9 – 9th or less
G10 – 10th
G11 – 11th
G12 – 12th
HSG – High school Graduate
GED – Gen. Ed. Diploma
COL – Some college/Training Certificate
A – Associate's Degree
B – Bachelor's Degree
M – Master's Degree

Employment Status - ES

F – Full time
P – Part time
S – Seasonal
T – Training
R – Retired/Disabled
U – Unemployed
B – Full time & Training
L – Part time & Training

Marital Status - MS

M – Married
S – Single
D – Divorced
W – Widowed
SP – Separated
DP – Domestic Partnership

Related To:

B12 – Both adults **A01 – Primary adult**
A02 – Second adult

ADULTS (List significant adult family members, beginning with Head of Household)

First and last name of adults in the home	*DOB*	*Sex*	*EL*	*ES*	*Occupation*	*MS*
A01		-	-	-		-
A02		-	-	-		-
A03		-	-	-		-

CHILDREN (List program applicant first, then any other children)

First and last name of children in the home	*DOB*	*Sex*	*Related To*
C01		-	☐ *B12* ☐ *A01* ☐ *A02*
C02		-	☐ *B12* ☐ *A01* ☐ *A02*
C03		-	☐ *B12* ☐ *A01* ☐ *A02*
C04		-	☐ *B12* ☐ *A01* ☐ *A02*