

Dear Parent/Guardian,

Thank you for your interest in the Early Head Start, Head Start and State Preschool Programs. We provide full-day and part-day preschool services, free of charge or low cost, to eligible families who live in Santa Clara and San Benito Counties. We also offer home-based and center-based services for newborn children to 36 months. Please fill out the application completely and if you need help, you can call us at **(408) 453-6900 or (800) 820-8182**, Monday through Friday from 8:00 am to 5:00 pm.

Please note that as part of the enrollment process, you will have an interview with a staff member.

DOCUMENTS YOU WILL NEED (Copies only; Originals will not be returned)

- Income Verification** – The documents need to show your income **for the past 12 months**. All parent(s) or guardian(s) income needs to be submitted. This includes, but not limited to:
 - **Pay Stubs for the past 12 Months, or recent 2 months** of pay stubs in combination with
 - **Latest Income Tax Return (1040) or W-2**
 - **Notice of Action** (if receiving CalWORKs or CalFresh/SNAP)
 - **Child Support**
 - **Supplemental Security Income (SSI)**
 - **Disability Income**
 - **Completed “Employer Income Verification”** (This is a form showing hours worked and pay rate - only if you do not have pay stubs)
- Birth Certificate(s)** (for enrolling child and all siblings under 18)
- Immunization Record**
- Proof of Address** (Example: phone bill, water bill, etc.)
- Current IEP (Individualized Education Plan) or IFSP (Individualized Family Service Plan)** (if applicable)
- Legal Documents/ Court Orders for Foster Child** (If Applicable)
- Full Day Verification** Full day requires that both parents/guardians must be working full time more than 30 hours per week or in school full time taking 12+ units (If applying for full day services)

SCHEDULE YOUR INTERVIEW

When you have gathered your documents and completed the application, **call our office and** an Early Learning Services Staff will help you schedule a date and time for an interview at a location near you. Please be sure to bring all the documents listed above and the completed application.

Please call 1 (408) 453-6900 or 1 (800) 820-8182 to schedule your appointment.

PLEASE NOTE:

If your child is accepted into the program, you will be **required** to present **current TB Risk Assessment and Physical Exam** within 30 days of enrollment. They may be submitted with the application if you have them.

ELS PRESCHOOL SERVICES APPLICATION

CPID _____

I would like to apply for

- AM Session PM Session Full Day* Single Session (6 Hours)
 EHS Full Day-(0-3 years old) EHS Family Child Care (0-3 years old) EHS Home Visiting (0-3 years old)

Child (Applicant)

First Name		Last Name		Middle	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date / /
Living Address				City/ Zip		Birth Country
Mailing Address (if different)				City/ Zip		
Is the child in foster care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic /Non-Latino	Race <input type="checkbox"/> Asian <input type="checkbox"/> White (European, Middle Eastern, North African) <input type="checkbox"/> Black/African American	<input type="checkbox"/> Pacific Islander/Hawaiian <input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> More than one race (Bi-racial/Multi-racial) <input type="checkbox"/> Other _____			

Family Information

Primary language spoken at home <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____					
What language does your child use the most? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____					
Does the child (applicant) have a sibling with a current IEP or IFSP? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Parents/Guardians in the Home <input type="checkbox"/> One Parent <input type="checkbox"/> Two Parents			What language would you like to receive written information? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese		
Primary Parent/Guardian's Name			Birth Date / /		Relationship to Child
Lives with the Child <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Cell Phone Number Opt in to received Text Message <input type="checkbox"/> Yes <input type="checkbox"/> No ()	Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Seasonally Employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Seeking Employment <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Incapacitated From _____ to _____		
Primary Parent/Guardian's Email Address			Alternate Phone Number <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other ()		Education <input type="checkbox"/> Less than High School <input type="checkbox"/> Some College or AA/AS <input type="checkbox"/> High School Grad or GED <input type="checkbox"/> Bachelor's or Advanced Degree
Secondary Parent/Guardian's Name			Birth Date / /		Relationship to Child
Lives with the Child <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Cell Phone Number Opt in to received Text Message <input type="checkbox"/> Yes <input type="checkbox"/> No ()	Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Seasonally Employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Seeking Employment <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Incapacitated From _____ to _____		
Secondary Parent/Guardian's Email Address			Alternate Phone Number <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other ()		Education <input type="checkbox"/> Less than High School <input type="checkbox"/> Some College or AA/AS <input type="checkbox"/> High School Grad or GED <input type="checkbox"/> Bachelor's or Advanced Degree

List all other family members living in the household for whom you are responsible for the care and welfare - NOT LISTED ABOVE:

First Name	Last Name	Date of Birth	Is this person related to the child's parent(s)?	Is this person supported by the parent'(s) income?
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Total number in your family (Including you) for whom you provide financial support Total number of people living in the house

Emergency Contact Information

Name	Phone	Relationship
	()	

ELS PRESCHOOL SERVICES APPLICATION

Child's Name _____

Birth Date _____

Family Living Situation (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Shelter
<input type="checkbox"/> Motel/Hotel
<input type="checkbox"/> Transitional Housing
<input type="checkbox"/> Single Room Occupancy (SRO)
<input type="checkbox"/> Car, Trailer, or Campsite
<input type="checkbox"/> Rented Garage | <input type="checkbox"/> Rented Trailer, Motor Home on Private Property
<input type="checkbox"/> Doubling/Tripling Occupancy due to economic hardship
<input type="checkbox"/> With another adult (Not the parent/legal guardian)
<input type="checkbox"/> Another Family's House/Apartment
<input type="checkbox"/> None of the options apply
<input type="checkbox"/> Other (Not designed for human beings) |
|---|--|

Primary Parent/Guardian

Primary Parent/Guardian's Name	Has Income <input type="checkbox"/> Y <input type="checkbox"/> N
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- Check all that apply. **Do you receive:**
- TANF/CalWORKs/CalFresh (SNAP)
 SSI
 Child Support
 Other sources of income _____

Employment Information

Employer Name	Employer Phone ()
Employer Name	Employer Phone ()
Pay Periods <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice Per Month <input type="checkbox"/> Monthly	
Gross Income \$ _____ Per _____	

School/Training Information

Are you in School or Training? <input type="checkbox"/> Yes <input type="checkbox"/> No		Units: _____
School Name	School Phone ()	

Secondary Parent/Guardian

Secondary Parent/Guardian's Name	Has Income <input type="checkbox"/> Y <input type="checkbox"/> N
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- Check all that apply. **Do you receive:**
- TANF/CalWORKs/CalFresh (SNAP)
 SSI
 Child Support
 Other sources of income _____

Employment Information

Employer Name	Employer Phone ()
Employer Name	Employer Phone ()
Pay Periods <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice Per Month <input type="checkbox"/> Monthly	
Gross Income \$ _____ Per _____	

School/Training Information

Are you in School or Training? <input type="checkbox"/> Yes <input type="checkbox"/> No		Units: _____
School Name	School Phone ()	

Medications

Has your child been diagnosed with a chronic health condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Does your child take prescribed medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will your child need to have prescribed medication at school? <input type="checkbox"/> Yes <input type="checkbox"/> No
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List all medicines, prescriptive that your child takes regularly and what kind, if any, side effects the child experiences

Your child will not be given medication at school without a physician's note and a Classroom Health Plan written with the parent and program staff.
 Does your child have any known food allergies or food restrictions? Yes No If yes please note _____

Special Devices

Does your child use any special device(s): <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what kind: _____	Does your child use any special device(s) at home: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what kind: _____
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Disabilities

Does your child have an Individualized Education Plan (IEP) with your local school district of residence or County Office of Education program? If yes, please attach copy of the most recent IEP.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child have an Individual Family Service Plan (IFSP) with an early intervention program, regional center, County Office of Education, or school district? If yes, please attach a copy of the most recent IFSP.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Technology Needs

Do you have reliable internet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Do you have computer device (Laptop, Computer, iPad, Tablet)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Do you have a smart phone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
How comfortable are you with technology and web base?	<input type="checkbox"/> Comfortable	<input type="checkbox"/> Little Comfortable	<input type="checkbox"/> Not comfortable

I certify that the information in this application is true and complete to the best of my knowledge. I understand that failure to report correct information may be grounds for rejection of this application or termination of childcare services.

Parent/Guardian's Signature _____ Date _____

Early Learning Services Staff's Signature _____ Date _____

At intake, please have parent sign below (Required for Annual Review)

Parent/Guardian's Signature _____ Date _____

REVIEW ANNUALLY WITH PARENTS/GUARDIANS