

Dear Parent/Guardian,

Thank you for your interest in the 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 or guardian income needs to be submitted. This includes, but not limited to:
  - **Pay Stubs for the past 12 Months**, or pay stubs in combination with:
    - **Latest Income Tax Return (1040) or W-2**
  - **Notice of Action** (if receiving CalWORKs)
  - **Child Support**
  - **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)

**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 before the first day of school**, and within 30 days of enrollment a current **Physical Exam** will be required. They may be submitted with the application if you have them.

**ELS PRESCHOOL SERVICES APPLICATION**

CPID \_\_\_\_\_

I would like to apply for  AM Session (3 ½ hrs.)  PM Session (3 ½ hrs.)  Full Day\* (9 hrs.)  Single Session (6 hrs.)  Home-Based  No Preference

\*Note: 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

**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		
<b>Is the child in foster care?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Ethnicity</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic /Non-Latino	<b>Race</b> <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			
Name of Person(s) Having Legal Custody of the Child		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
<b>Lives with the Child</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Marital Status</b> <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<b>Cell Phone Number</b> Opt in to received Text Message <input type="checkbox"/> Yes <input type="checkbox"/> No ( )	<b>Employment Status</b> <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		<b>Alternate Phone Number</b> <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other ( )	<b>Education</b> <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
<b>Lives with the Child</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Marital Status</b> <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<b>Cell Phone Number</b> Opt in to received Text Message <input type="checkbox"/> Yes <input type="checkbox"/> No ( )	<b>Employment Status</b> <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 _____
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**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 of people living in the household (including you) for whom you provide financial support

**Emergency Contact Information**

Name	Phone ( )	Relationship

# ELS PRESCHOOL SERVICES APPLICATION

Child's Name \_\_\_\_\_

Birth Date \_\_\_\_\_

Family Residency	
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"/> 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)

Eligibility																																													
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #f2f2f2;"> <th colspan="2" style="text-align: left; padding: 5px;">Primary Parent/Guardian</th> </tr> </thead> <tbody> <tr> <td style="width: 70%; padding: 5px;">Primary Parent/Guardian's Name</td> <td style="width: 30%; padding: 5px;">Has Income <input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td colspan="2" style="padding: 5px;">                     Check all that apply  <b>Do you receive:</b>  <input type="checkbox"/> TANF/CalWORKs (no food stamps) <input type="checkbox"/> SSI <input type="checkbox"/> Child Support  <input type="checkbox"/> Other sources of income _____                 </td> </tr> <tr style="background-color: #f2f2f2;"> <th colspan="2" style="text-align: left; padding: 5px;">Employment Information</th> </tr> <tr> <td style="padding: 5px;">Employer Name</td> <td style="padding: 5px;">Employer Phone (    )</td> </tr> <tr> <td style="padding: 5px;">Employer Name</td> <td style="padding: 5px;">Employer Phone (    )</td> </tr> <tr> <td colspan="2" style="padding: 5px;"> <b>Pay Periods</b> <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice Per Month <input type="checkbox"/> Monthly                 </td> </tr> <tr style="background-color: #f2f2f2;"> <th colspan="2" style="text-align: left; padding: 5px;">School/Training Information</th> </tr> <tr> <td colspan="2" style="padding: 5px;">                     Are you in School or Training? 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Health History Information	
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
<b>List all medicines, prescriptive that your child takes regularly and what kind, if any, side effects the child experiences</b>  <i>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.</i> Does your child have any known food allergies or food restrictions <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____
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. <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
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. <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
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 Signature _____	Date _____
Early Learning Services Staff's Signature _____	Date _____
<i>At intake, please have parent sign below (Required for Annual Review)</i>	
Parent/Guardian Signature _____	Date _____

**REVIEW ANNUALLY WITH PARENTS/GUARDIANS**