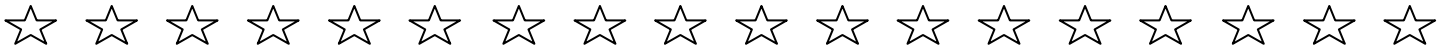


Community Services for Children, Inc.
1520 Hanover Avenue • Allentown, PA 18109
610-437-6000 • www.cscinc.org

APPLICATION FOR PRESCHOOL PROGRAMS

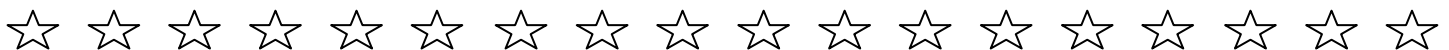
OUR PRESCHOOL PROGRAMS:

- ❖ **Early Head Start**- Services to pregnant women and infants through age 3
- ❖ **Head Start/Head Start Pre-K Counts**- Preschool for children 1 and 2 years before kindergarten with health and family services



HOW TO APPLY FOR ONE OF OUR PROGRAMS:

- ❖ **Application**- Complete the attached application. If you need any help, please call us at 610- 437-6000, ext. 2354.
- ❖ **Date of Birth**- Provide a copy of your child’s birth certificate or other document identifying your child’s date of birth.
- ❖ **Income**- Provide documents to verify your household income for the past 12 months. This may include:
 - ✓ Pay stubs or unemployment check
 - ✓ W2 forms
 - ✓ Tax Form 1040
 - ✓ A written statement from an employer
 - ✓ TANF statement
 - ✓ If you are unable to send documentation of your income, please send a signed letter describing your circumstance.
- ❖ **Mail or Fax**- Application and above documents:
 - ✓ 1520 Hanover Avenue, Allentown, PA 18109
 - ✓ Fax: 610-437-6500 - ATTN: Enrollment Department



WHAT HAPPENS NEXT:

- ❖ **Review** –Based on the information you give us and eligibility guidelines, we will let you know by mail if you are eligible.
- ❖ **Selection** – Children are selected for the upcoming school year during the spring. We accept applications year-round. When we have an opening for your child, we will contact you to complete the enrollment process.
- ❖ **Priority** – We prioritize children based on age, income, disabilities and other risk factors that show a high need for services.

APPLICATION FOR EARLY HEAD START/HEAD START/HEAD START-PRE K COUNTS

Child or Pregnant Mother Applicant

Date Application Completed: _____

Person Completing: _____

Last Name (Child/Pregnant Mother)	First Name (Child/Pregnant Mother)	Middle Initial
Child:	Child:	
Pregnant Mom:	Pregnant Mom:	

Date of Birth/ Estimated Due Date	Age	Gender	Household (Family) Size
/ /	<input type="checkbox"/> under 1 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 1 year before K <input type="checkbox"/> 2 years before K	<input type="checkbox"/> Male <input type="checkbox"/> Female	___ # of Adults ___ # of Children (including eligible child)

Primary Language (child/pregnant mother)	How Well Does Applicant Speak English?	Race of Applicant	Family Type
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ (Please specify)	<input type="checkbox"/> Not At All <input type="checkbox"/> Not Well <input type="checkbox"/> Well <input type="checkbox"/> Very Well	<input type="checkbox"/> Migrant Child/ Family	<input type="checkbox"/> One Parent <input type="checkbox"/> Two Parent <input type="checkbox"/> Foster <input type="checkbox"/> Relative/Grandparent <input type="checkbox"/> Other _____ <i>If child is being cared for by someone other than a biological parent, proof of legal guardianship will be required to officially enroll the child in the program.</i>

Living Address (street, city and zip):	Mailing Address (street, city and zip):	Daytime Caregiver (street, city and zip):
	<input type="checkbox"/> Same as Living Address	
Home/Cell Telephone:	Work Phone:	County of Residence:
		<input type="checkbox"/> Lehigh <input type="checkbox"/> Northampton
School District:	Primary Language of Head of Household:	
	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ (Please specify)	
How Did You Hear About Head Start/Early Head Start? If a Referral, Identify the Referral Source:		

Household Members					
Please list all parents/guardians and children up to age 18 living at the address listed above.					
	Relationship to Child	Date of Birth	Work, Training, or School	Highest Level of Education	Race and Ethnicity
Head of Household/Guardian					
Parent/Guardian					
Other Family Member/Child					
Other Family Member/Child					
Other Family Member/Child					
Other Family Member/Child					

CHILD/FAMILY ELIGIBILITY FACTORS

Community Services Used by Your Family in the Past Year (check all that apply):

- Housing/Section 8 WIC D&A Treatment Corrections/Probation Community Action Turning Point
 Adult Education/College Family/Individual/Marriage Counseling Family Literacy/ESL Program Child Welfare Involvement

Do You Have Any Concerns About Your Child's Development (check all that apply):

- Physical Development Vision Speech Hearing Behavior Health Other

Please Describe Your Concerns: _____

Does Your Child Have a Current IFSP/IEP? Yes No

If Yes, Please Indicate the Early Intervention/IU Services Your Child is Currently Receiving:

- Speech Development Hearing Language Vision Occupational/Physical Therapy

Is Your Child Currently Enrolled in an IU Classroom: Yes No **If yes, where:** _____

Does Your Child Currently Use An Assistive Device (for example, wheelchair, walker, braces, etc.): Yes No

If yes, please specify: _____

Does Your Child Need Physical Assistance (for example, cannot walk long distances, needs assistance feeding, needs help with stairs)?

- Yes No **If yes, please specify:** _____

Is Your Child Currently Receiving Behavioral Supports or Mental Health Treatment? Yes No

If yes, please identify the provider: _____

Are You or Were You a Teen Parent? Yes No **Age of First Pregnancy** _____

Are You Currently Pregnant? Yes No **Estimated Due Date:** _____

If You Are a Pregnant Mother, Are You Currently Receiving Prenatal Care? Yes No

If Yes, Where? _____ **When Did Your Care Begin?** _____

Temporary Living Condition (TLC): A child/family who lacks a fixed, regular, or adequate nighttime residence. For example:

- Family is sharing the housing of other persons due to loss of housing, economic hardship or similar reason; are living in motels or hotels due to the lack of alternative accommodations; are living in emergency or transitional shelters; or are awaiting foster care placement;
- Family has a primary nighttime residence that is a public or private place not designated for or ordinary used as a regular sleeping accommodation for human beings;
- Family is living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings.

Based on Above Definition, Are you Currently in a Temporary Living Condition (TLC): Yes No

Length of Time in TLC: Less than 1 month 1-3 months 3-6 months 6+months

Are you currently or were you previously enrolled in:

Early Head Start _____ (date and location)

Head Start _____ (date and location)

Pre K Counts _____ (date and location)

Child Care Subsidy _____ (date only)

I am the legal guardian of this child and certify, that, to the best of my knowledge, all of the information that I have provided is complete and correct. I understand that this is an application only and does not guarantee enrollment into the program.

Assurance of Confidentiality: The information on this application is being requested on a voluntary basis. The information you provide will help us to deliver services most appropriate for your family's needs. If you prefer not to provide some information, it will not affect the services we deliver. However, some information is required for eligibility determination. All information will be held in strict confidence. I give permission for this information to be shared with the PA Office of Child Development and Early Learning (OCDEL) and Child Care Works for reporting purposes if my child becomes enrolled.

Parent/Guardian's Signature

Date

Parent/Guardian's Signature

Date