Center For Family Resources

PREGNANT WOMAN ELIGIBILITY APPLICATION
EARLY HEAD START

ALL SECTIONS MUST BE COMPLETED

SERVUE: Child ID _____ Family ID _____
Return to: ___FMJ ___PL ___RW ___ Wayne ___WM
Approved by:_____ Date_____
__ Income Eligible ___101-130 ___Over Income
Home Visitor: _____
Please Circle One: FDFY 4 Day 5 Day FCC CO EHS
Circle all applicable: HOMELESS IE 101 OI FOSTER SN TANF DCP&P SSI

Date: _____
Staff Name: _____
Return to:_____(site)

Name: _____ DOB:_____ Age:_____ Due Date: _____

Address: _____ City: _____ State: **New Jersey** Zip Code: _____

Housing Status: Own?____ Rent?____ Emergency Shelter?_____ Transitional Housing?_____ Live with relatives?_____ Other?_____

Home Phone No._____ Cell No._____ Job/School No. _____ E-Mail:_____

Highest Level of Education completed:_____ Language Primary: _____ Secondary:_____

Ethnicity: ___Hispanic ___Non-Hispanic

Race: (Circle One) American Indian Asian Bi/Multi-Racial Black/African American White Other:_____

Total Family Size: _____ Marital Status_____ Referred by:_____
(Count Pregnant women as 2)

Emergency Contact: _____ Telephone No. _____

Receiving: ____TANF ____Post TANF If yes, how long ago? _____ ____ SNAP ____ WIC ____SSI

Active DCP&P Case_____ If yes worker's name_____

Attending Physician:_____ Type of Transportation: _____

Name of Insurance Provider:_____ NJ Family Care __Y __N Private Insurance __Y __N Other:_____

Income Data

	Circle One	Name of Employer/School	Hours/Days a Week	Gross Income	Annual Gross Income
Mother	Work Unemployment School Not Working		Work/School Schedule (ex: 9-5 M-F) _____ Days a Week_____ Hours a Week_____	$_____ Weekly/Bi-Weekly	$_____
Father	Work Unemployment School Not Working		Work/School Schedule (ex: 9-5 M-F) _____ Days a Week_____ Hours a Week_____	$_____ Weekly/Bi-Weekly	$_____
				Total Family Income	$_____

Other Dependents in Household

Last Name	First Name	Sex	Age	DOB	School	Current Grade	Relationship to Applicant

Secondary Caregiver

Last Name	First Name	Sex	Age	DOB	Highest Level of Education Completed	Relationship to Applicant

General Information

(a). What type of future program option do you prefer ? (Circle one) **Early Head Start** **Home-Based** **Family Child Care**
Preferred Center: _____(location)

(b). A parent with a disability/illness? Yes No If yes, explain_____
Has parent previously experienced post-partum depression? Yes No

(c). Does any child:

1. Have a medical condition? Yes No If yes, explain:_____
2. Receive Therapy? Yes No If yes, circle all that apply: Speech, Occupational Therapy, Physical Therapy, Other:_____
3. Does child have Disability or suspected disability? Yes No If yes, explain:_____
4. Have a speech or developmental evaluation? Yes No If yes, explain: _____
5. Other_____

My signature verifies that the above information is correct and to the best of my knowledge as reported to Center For Family Resources staff. Providing false or misleading information may result in my unborn child not being accepted to the Head Start program.

Parent/Guardian Signature:_____Date:_____ Staff Signature_____ Date:_____

Guardian/Parent Name (if under 18 yrs.): _____ Date:_____

Send original eligibility application to Ringwood – Attn: Social Service Manager Send Copies to: (If questions #7: c3-c6 are yes –send copy to Special Services Manager

Revised 2/20/13

THIS APPLICATION EXPIRES DECEMBER 31, 2013