



Quincy Community Action Programs, Inc

EARLY HEAD START/HEAD START
ENROLLMENT APPLICATION
(All information will be kept confidential)



Section 1 Services to Expectant Family

Name of Pregnant Woman _____ Expected Due Date _____
Skip section 2, complete section 3 and 4

Section 2 Child's Information

Name _____ Sex: M/F DOB _____ Primary Language _____
Race/Ethnicity (please circle) Black/Not Hispanic, White/Not Hispanic, Hispanic Origin, Native American/Alaskan, Asian/Pacific, Other _____

Section 3 Parent/Guardian and or Expectant Family Information

Name _____ DOB _____

Address _____ E-mail address _____
Street Town Zip Code

Primary Phone _____ Alternate Phone _____
(please circle) cell or home (please circle) cell or work

Race/Ethnicity _____ Primary Language _____ Relationship to Child _____

Educational Level (please circle) 9-12/non graduate, high school grad/GED, some college, Bachelor's degree, Master's degree

Monthly Income \$ _____ Number of hours worked per week _____

Source of Income: (please circle) Wages, TANF, SS, V.A. Benefits, Child Support, Military Benefits, Unemployment

Name _____ DOB _____

Address _____ E-mail address _____
Street Town Zip Code

Primary Phone _____ Alternate Phone _____
(please circle) cell or home (please circle) cell or work

Race/Ethnicity _____ Primary Language _____ Relationship to Child _____

Educational Level (please circle) 9-12/non graduate, high school grad/GED, some college, Bachelor's degree, Master's degree

Monthly Income \$ _____ Number of hours worked per week _____

Source of Income: (please circle) Wages, TANF, SS, V.A. Benefits, Child Support, Military Benefits, Unemployment

Are you homeless? Yes/No

Family Type (please circle) Single Parent/Female, Single Parent/Male, Two-Parent Household, Foster Family

Section 4 Additional Information

Please list all members of your household that you are financially responsible for:

Name	M/F	DOB	Name	M/F	DOB
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Please check any areas of concerns for your child:

	Parental Concern	Receiving Services		Parental Concern	Receiving Services
Speech/Language	_____	_____	Dental	_____	_____
Social/Emotional	_____	_____	Health/Vision/Hearing	_____	_____
Nutrition	_____	_____	Fetal Development	_____	_____

Parent/Guardian Signature(s) _____

Date of Application _____

QCAP Staff Signature _____ Date of Entry _____