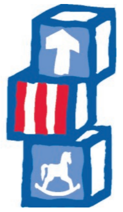
I am applying for:
- ☐ Home Visiting Program
- ☐ Center-Based Program (Nelson, Comstock, NEIS, Sage)
- ☐ First Available (Home Visiting or Center-based)
- ☐ Combination Program (WCSD Student)

Early Head Start

Serving Pregnant Women,
Infants and Toddlers up to age 3

Application for Enrollment



Adult Applicant's Name: ____
First Name *MI* *Last Name(s)*

Date of Birth: _____ / _____ / _____ **Relationship to child:** ☐ Mother ☐ Father ☐ Other ______________________
Specify

Address: ____
Street *Apt.#*

____
City *State* *Zip Code*

______________________ ______________________ ______________________
Home Phone *Work Phone* *Cell/Message Phone*

This address is: ☐ *House* ☐ *Apartment* ☐ *Friend/Relative's house* ☐ *Motel/Transitional House* ☐ *Recreational Vehicle*

Applicant's Language(s) Spoken: *Primary*: ______________________ *Secondary:* ______________________

Applicant's English Speaking Ability: ☐ *Very well* ☐ *Well* ☐ *Not Well* ☐ *Not at all*

Is Applicant Currently Pregnant? ☐ *Yes (If yes, what is your due date? ______/______/______)* ☐ *No*

Occupational Status *(check all that apply):*

☐ **Paying job** *(please attach pay stub) Employer:* ______________________ ☐ *Full-time (32+ hrs/week)* ☐ *Part-time*

☐ **In school** *(please attach school schedule) School:* ______________________ ☐ *Full-time* ☐ *Part-time*

☐ **In job training program** *(please attach verification) Program:* ______________________ ☐ *Paid* ☐ *Unpaid*

☐ **Unemployed** ☐ *Work experience* ☐ *No work experience*

☐ **Other:** ☐ *Homemaker* ☐ *Retired* ☐ *Unable to work due to disability*

Complete the section below for each child in the family eligible to receive direct services through Early Head Start.

Child's Name : ____
First Name *MI* *Last Name(s)*

Date of Birth: _____ / _____ / _____ **Gender:** ☐ *Male* ☐ *Female*

Child's Name : ____
First Name *MI* *Last Name(s)*

Date of Birth: _____ / _____ / _____ **Gender:** ☐ *Male* ☐ *Female*

Child(ren)'s relationship to adult applicant: ____

Do any of the above children have a documented special need? ☐ *Yes (please attach verification)* ☐ *No*

Indicate which child*:* ______________________ **Special Concern:** ______________________

Other Family Members in home:

Name	*Date of Birth*	*Relationship to Child(ren)*
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Agency Referral Information

Were you referred by another agency? ☐ **NO** ☐ **YES:** ______________________________

If yes, *please submit referral with your application.*

Family Eligibility Verification

A family is all persons:

- Living in the same household, **AND**
- Supported by the income of the parent(s) or guardian of the child being enrolled **AND** related by blood, marriage or adoption.

To be placed on the waiting list we need to verify:

- Family income from the last calendar year, **OR**
- The previous 12 months (whichever is less) **AND**
- Proof of Birth **OR**
- Proof of Pregnancy

****APPLICATIONS SUBMITTED WITHOUT INCOME NFORMATION CANNOT BE PROCESSED****

I certify that all of the information provided in this application is accurate and truthful to the best of my knowledge.

Signature: ______________________________ (Required) **Date:** ______/______/______ MM DD YYYY

AGENCY USE ONLY

Type of Eligibility	Method of Income Verification	(Staff use Only)
☐ Public Assistance, i.e., TANF	☐ 1040 Tax Statement	$ ________ per________
☐ Foster Child Verification Letter	☐ Earnings (Pay stubs, W2s)	$ ________ per________
☐ Homelessness Verification Letter	☐ Unemployment Compensation	$ ________ per________
☐ Social Security Income	☐ Educational Assistance	$ ________ per________
☐ Income Under 100% of Poverty Level	☐ Alimony and/or Child Support	$ ________ per________
O Last calendar year total: $ __________ **OR**	☐ Other financial assistance	$ ________ per________
O Previous 12 month total: $ __________	☐ Written Income Statement	$ ________ per________

Size of family unit: _________ HHS Income Guideline: $ ____________________ Percentage: __________%

Staff signature ______________________________ Date: _____/_____/_____ Total points: _________

University of Nevada, Reno — Early Head Start — Mail Stop 392, Reno, NV 89557
Phone: 775-327-5100 Fax: 775-327-5866