



General Information

CDCFC Head Start

Enriching the lives of children and families.

Child Name _____ **DOB:** _____

Parent Name _____ **DOB:** _____

Household Member Name _____ **DOB:** _____

Household Member Name _____ **DOB:** _____

Household Member Name _____ **DOB:** _____

Address: _____

Phone #: _____ Opt in for text messages: Y N

Email: _____

Best day(s) to contact: M T W TH F Child Allergies? Y or N _____

Best time to contact: _____ Drop off time (AM): _____ Pick up time (PM): _____

Do you receive **WIC?** -Y or N **Pregnant?** Y or N **Highest level of Education?** _____

Medical Insurance? Y or N Name of Insurance _____

Income - documentation will be needed to verify program eligibility (recent pay stub, 1040, W-2, SSI, TANF, OWF, etc.)

Employer _____ Occupation? _____ Total number of people in the household: _____

Race? _____ Ethnicity? _____ Primary Language spoke at home other than English _____

Do you receive any of the following (**Automatic Qualifier**) (circle all that apply) **Foster child/Kinship--SSI, --TANF--OWF/Cash Assistance-- SNAP?**

THANK YOU! I WILL CONTACT YOU SOON TO SET UP A TIME TO COMPLETE THE APPLICATION PROCESS!

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