

1 (408) 453-6900 or 1 (800) 820-8182

Dear Parent/Guardian,

Thank you for your interest in the Head Start and State Preschool Programs. We provide full-day and part-day preschool services, free of charge or low cost, to eligible families who live in Santa Clara and San Benito Counties. We also offer home-based and center-based services for newborn children to 36 months. Please fill out the application completely and if you need help, you can call us at (408) 453-6900 or (800) 820-8182, Monday through Friday from 8:00 am to 5:00 pm.

Please note that as part of the enrollment process, you will have an interview with a staff member.

DOCUMENTS YOU WILL NEED (Copies only; these will not be returned)

- Income Verification** – The documents need to show your income **for the past 12 months**. All parent or guardian income needs to be submitted. This includes:
 - **Pay Stubs for the past 12 Months**, or pay stubs in combination with:
 - **Latest Income Tax Return (1040) or W-2**
 - **Notice of Action** (if receiving CalWORKs)
 - **Proof of SSI - Supplemental Security Income** (if applicable)
 - **Unemployment Income**
 - **Worker's Compensation**
 - **Child Support**
 - **Disability Income**
 - **Completed "Employer Income Verification"** (This is a form showing hours worked and pay rate - only if you do not have pay stubs)
- Birth Certificate(s)** (for the child and all siblings under 18)
- Proof of Address** (Like a phone bill, water bill, etc.)
- Immunization Records**
- TB Assessment or TB Test Results**
- Current Physical Exam** (submit current physical exam, if possible)
- Proof of Legal Custody** (if the child is in foster care)
- Homeless Verification** (if applicable and if available)
- Current IEP (Individualized Education Program) or IFSP (Individualized Family Service Plan)** (if applicable)
- Full Time Employment or School/Training Verification** (if you would like full day services)

SCHEDULE YOUR INTERVIEW

When you have gathered your documents and completed the application, **call (408) 453-6900**. A Head Start Staff will call you back to schedule a date and time for an interview at a location near you. Please be sure to bring all the documents listed above and the completed application.

Please call 1 (408) 453-6900 or 1 (800) 820-8182 to schedule your appointment.

ELS PRESCHOOL SERVICES APPLICATION

I would like to apply for AM Session (3 ½ hrs.) PM Session (3 ½ hrs.) Full Day* (9 hrs.) Single Session (6 hrs.) Home-Based No Preference

*Note: Full day requires that both parents/guardians must be working full time more than 30 hours per week or in school full time taking 12+ units

Child (Applicant)					
First Name		Last Name	Middle	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date / /
Living Address			City/ Zip	Birth Country	
Mailing Address (if different)			City/ Zip		
Is the child in foster care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic /Non-Latino	Race <input type="checkbox"/> Asian <input type="checkbox"/> White (European, Middle Eastern, North African) <input type="checkbox"/> Black/African American	<input type="checkbox"/> Pacific Islander/Hawaiian <input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> More than one race (Bi-racial/Multi-racial) <input type="checkbox"/> Other _____		

Does the child have a current IEP or IFSP? Yes No If yes, please complete the Disabilities section of this application

Family Information

Primary language spoken at home <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____					
What language does your child use the most? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____					
Does the child (applicant) have a sibling with a current IEP or IFSP? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Name of Person(s) Having Legal Custody of the Child		Parents/Guardians in the Home <input type="checkbox"/> One Parent <input type="checkbox"/> Two Parents	Primary Email Address		
Primary Parent/Guardian's Name			Birth Date / /	Relationship to Child	
Lives with the Child <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Primary Phone Number <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other ()	Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Seasonally Employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Seeking Employment <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Incapacitated From _____ to _____		
Primary Parent/Guardian's Email Address		Alternate Phone Number <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other ()	Education <input type="checkbox"/> Less than High School <input type="checkbox"/> Some College or AA/AS <input type="checkbox"/> High School Grad or GED <input type="checkbox"/> Bachelor's or Advanced Degree		

Secondary Parent/Guardian's Name			Birth Date / /	Relationship to Child	
Lives with the Child <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Primary Phone Number <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other ()	Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Seasonally Employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Seeking Employment <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Incapacitated From _____ to _____		
Secondary Parent/Guardian's Email Address		Alternate Phone Number <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other ()	Education <input type="checkbox"/> Less than High School <input type="checkbox"/> Some College or AA/AS <input type="checkbox"/> High School Grad or GED <input type="checkbox"/> Bachelor's or Advanced Degree		

List all other family members living in the household for whom you are responsible for the care and welfare - NOT LISTED ABOVE:

First Name	Last Name	Date of Birth	Is this person related to the child's parent(s)?	Is this person supported by the parent's income?
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Total number of people living in the household (including you) for whom you provide financial support

ELS PRESCHOOL SERVICES APPLICATION

Child's Name _____

Birth Date _____

Emergency Contact Information

Name	Phone	Relationship
	()	
	()	

Family Residency

Temporarily in one of the following due to inadequate housing, financial hardship, or loss of housing

Family Living Situation (Check all that apply)

<input type="checkbox"/> Shelter Name _____ <input type="checkbox"/> Motel/Hotel Name _____ <input type="checkbox"/> Transitional Housing Name _____ <input type="checkbox"/> Single Room Occupancy (SRO) <input type="checkbox"/> Car, Trailer, or Campsite <input type="checkbox"/> Rented Garage <input type="checkbox"/> Rented Trailer, Motor Home on Private Property	<input type="checkbox"/> With another adult (Not the parent/legal guardian) <input type="checkbox"/> Another Family's House/Apartment <input type="checkbox"/> None of the options apply <input type="checkbox"/> Other (Not designed for human beings) Explain: _____ _____
---	---

Eligibility

Primary Parent/Guardian

Primary Parent/Guardian's Name	Has Income <input type="checkbox"/> Y <input type="checkbox"/> N
--------------------------------	---

Check all that apply

Do you receive:	Monthly Amount
<input type="checkbox"/> TANF/CalWORKs (no food stamps)	\$ _____
<input type="checkbox"/> SSI	\$ _____
<input type="checkbox"/> Child Support	\$ _____
<input type="checkbox"/> Other sources of income	\$ _____

Employment Information

Employer Name	Employer Phone ()
Employer Name	Employer Phone ()

Pay Periods Weekly Every 2 Weeks Twice Per Month Monthly

Gross Income \$ _____ Per _____

School/Training Information

Are you in School or Training? <input type="checkbox"/> Yes <input type="checkbox"/> No	
School Name	School Phone ()
School Units _____	

Secondary Parent/Guardian

Secondary Parent/Guardian's Name	Has Income <input type="checkbox"/> Y <input type="checkbox"/> N
----------------------------------	---

Check all that apply

Do you receive:	Monthly Amount
<input type="checkbox"/> TANF/CalWORKs (no food stamps)	\$ _____
<input type="checkbox"/> SSI	\$ _____
<input type="checkbox"/> Child Support	\$ _____
<input type="checkbox"/> Other sources of income	\$ _____

Employment Information

Employer Name	Employer Phone ()
Employer Name	Employer Phone ()

Pay Periods Weekly Every 2 Weeks Twice Per Month Monthly

Gross Income \$ _____ Per _____

School/Training Information

Are you in School or Training? <input type="checkbox"/> Yes <input type="checkbox"/> No	
School Name	School Phone ()
School Units _____	

Parent/Guardian's Signature _____	Date _____
Early Learning Services Staff's Signature _____	Date _____
<i>At intake, please have parent sign below (Required for Annual Review)</i>	
Parent/Guardian's Signature _____	Date _____

REVIEW ANNUALLY WITH PARENTS/GUARDIANS

ELS PRESCHOOL SERVICES APPLICATION

Child's Name _____

Birth Date _____

Health History Information					
Medications					
Does your child take prescribed medications? <input type="checkbox"/> Yes <input type="checkbox"/> No		Will your child need to have medication at school? <input type="checkbox"/> Yes <input type="checkbox"/> No			
List all medicines, prescriptive and non-prescriptive that your child takes regularly and what kind, if any, side effects the child experiences					
<i>Your child will not be given medication at school without a physician's note and a Classroom Health Plan written with the parent and program staff.</i>					
Special Devices					
Does your child use any special device(s): <input type="checkbox"/> Yes <input type="checkbox"/> No		Does your child use any special device(s) at home: <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, what kind:		If yes, what kind:			
Special Health Needs / Chronic and Past Illnesses					
Check illness that the child has had or currently has, and specify approximate dates of illnesses:					
Dates		Dates		Dates	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Ten-day Measles (Rubeola)	
<input type="checkbox"/> Anemia		<input type="checkbox"/> Mumps		<input type="checkbox"/> Three-day Measles (Rubella)	
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Poliomyelitis		<input type="checkbox"/> Whooping cough	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Pediatric First Aid Needs	
<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Seizures		<input type="checkbox"/> Other:	
Does your child have frequent colds? <input type="checkbox"/> Yes <input type="checkbox"/> No		How many in the last year?			
Insurance Information					
Do you currently have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Insurance	<input type="checkbox"/> California Children's Services CCS	<input type="checkbox"/> CHDP		
		<input type="checkbox"/> Medi-Cal Santa Clara Family Health Plan	<input type="checkbox"/> SCC Healthy Kids HMO		
		<input type="checkbox"/> Medi-Cal Anthem Blue Cross	<input type="checkbox"/> Healthy Families		
		<input type="checkbox"/> Private Medical Insurance:	<input type="checkbox"/> Uninsured → Referred To:		
Usual Source of Health Care					
Is child presently under a doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Provider Physician/Clinic:	Name	()		Phone	
		Street Address		City/Zip Code	
Dentist:	Name	()		Phone	
		Street Address		City/Zip Code	
Other:	Name	()		Phone	
		Street Address		City/Zip Code	
Do you have any concerns about your child's health?					
What is the plan for care when the child is ill?					
REQUIRED HEALTH ASSESSMENT (PHYSICAL EXAM)					
A health assessment (physical examination) by a physician is required. If you do not have a copy of a current physical exam for your child, you will be asked to take your child to the doctor within 30 days of the first day of school to obtain one. It is best to do this before your child is placed on a class list (see attached Child Health Assessment form).					
Is a copy of a current Physical Exam included with the application? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Child's Last Physical:			
REQUIRED DENTAL EXAM (CHILDREN AGES 1-5 YEARS OLD)					
A dental exam by a dentist is required starting at 12 months. If you do not have a copy of a current dental exam for your child, you will be asked to take your child to the dentist within 90 days of the first day of school to obtain one. It is best to do this before your child is placed on a class list (see attached Dental Examination form).					
Is a copy of a current Dental Exam included with the application? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Child's Last Dental Visit:			
Do you need assistance in finding a health or dental provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please indicate: <input type="checkbox"/> Dental <input type="checkbox"/> Medical			

AN INCOMPLETE APPLICATION WILL DELAY ENROLLMENT

ELS PRESCHOOL SERVICES APPLICATION

Child's Name _____

Birth Date _____

Health History Information cont'd			
Developmental History			
Child walked at: _____ months	Child began talking at: _____ months		
Social-Emotional Development			
Describe your child's personality:			
Does the child have	Does the child have		
Problems getting along with other children the same age? <input type="checkbox"/> Yes <input type="checkbox"/> No	Aggressive behavior? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Problems getting along with other family members? <input type="checkbox"/> Yes <input type="checkbox"/> No	Extreme shyness? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Problems sleeping? <input type="checkbox"/> Yes <input type="checkbox"/> No	Problems separating from parent/guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Temper tantrums? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other concerns you may have about your child's behavior <input type="checkbox"/> Yes <input type="checkbox"/> No		
Severe fears? <input type="checkbox"/> Yes <input type="checkbox"/> No	Currently receiving mental health services? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has the child had group play experiences? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, agency name		
Disabilities			
Does your child have an Individualized Education Plan (IEP) with your local school district of residence or County Office of Education program? If yes, please attach copy of the most recent IEP. <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does your child have an Individual Family Service Plan (IFSP) with an early intervention program, regional center, County Office of Education, or school district? If yes, please attach a copy of the most recent IFSP. <input type="checkbox"/> Yes <input type="checkbox"/> No			
Additional information about your child's disability or other developmental concerns. Please explain if checked "yes" above.			
Ears and Eyes			
Do you have any concerns about your child's hearing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any concerns about your child's vision? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Allergies			
List all allergies (food or other)			
Has your child been prescribed medication for an allergic reaction? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Daily Routines			
Sleeping Routine			
What time does your child get up?	Does your child take naps? <input type="checkbox"/> Yes <input type="checkbox"/> No		
What time does your child go to bed?	If yes, when?	How long?	
Diet Pattern			
What does your child usually eat for these meals?	What are the usual eating hours?		
Breakfast	Breakfast		
Lunch	Lunch		
Dinner	Dinner		
Any food dislikes?	Any eating problems?		
List special diets to accommodate for cultural preference or for religious or medical reasons (indicate what specific foods are included)			
<i>A Classroom Nutrition Plan will be written with the parent and program staff to address all allergies and special diets.</i>			
Toileting			
Toilet training started at: _____ months	Is your child Toilet Trained? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are bowel movements regular? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If Yes, at what stage:	What is his/her usual time?	
Word used for "Bowel Movement":	Word used for "Urination":		

REVIEW ANNUALLY WITH PARENTS/GUARDIAN

ELS PRESCHOOL SERVICES APPLICATION

Child's Name _____

Birth Date _____

Parent Authorization for Program Services

I understand that the Early Learning Services Preschool programs are comprehensive programs that will provide many services to support my child and family. Classroom observations and screenings are part of the program, which enable staff and SCCOE's DataZone (Internal Department) to share data in order to plan for my child's individual development and for ongoing program improvement. I understand that the Early Learning Services Program will keep me informed as each service is completed and will provide me the results of all procedures and services my child receives. As part of my child's enrollment in Early Learning Services Preschool programs, my child will be assigned a Statewide Student Identifier (SSID).

While children with special needs are already assigned a Statewide Student Identifier (SSID) in most early learner programs, this is the first time that we are entering a large number of preschool children into California Longitudinal Pupil Achievement Data System (CALPADS) before their entry to kindergarten. This ground-breaking effort will provide participating school districts and lead agencies the ability to share data to better improve services to your child.

I give permission for Early Learning Services staff to complete the following with my child:

Yes No

- | | | |
|---|--|---|
| <ul style="list-style-type: none">▪ Dental Screening▪ Nutrition Assessment | <ul style="list-style-type: none">▪ Vision & Hearing Screenings▪ Blood Pressure▪ Height & Weight | <ul style="list-style-type: none">▪ Social Emotional Screening / Behavioral Health Consultation▪ Developmental Screenings / Other Services |
|---|--|---|

Parent/Guardian's Signature

Date

Staff's Signature

Date

Agreement to Release Information

All release of information about my child will follow the procedural safeguards outlined in the provisions of Federal and State Administrative Codes: Health Insurance Portability and Private Act, (HIPAA), 2003; Family Educational Rights and Privacy Act, (FERPA), 2009; Individuals with Disabilities Education Improvement Act, (IDEA), 2004; and Head Start Performance Standards 1302.41(b)(1), 1302.45(a)(3), 1303.21 (a)(b), 1305.2.

I understand this information is strictly confidential and will be used to better provide support services and to permit data sharing, understanding to improve program quality. This authorization shall be valid for one year from the date it is signed.

I certify that the information in this application is true and complete to the best of my knowledge. I understand that failure to report correct information may be grounds for rejection of this application or termination of childcare services. I will notify the agency immediately if there is any change in my income, family size, residence, employment, or reason for needing childcare services.

Parent/Guardian's Signature

Date

Parent/Guardian's Signature (Required for Annual Review)

Date (Required for Annual Review)