

## Early Head Start Application

Thank you for your interest in Head Start.

Please print this application, fill it out, and send it to: **218 Putnam Street, Marietta, OH 45750** (even if you are interested in Head Start in another town or county).

Please keep in mind that sending in this application does not mean your child has been automatically accepted into our program. The return of this application gives us the information we need to contact you about specific details (income, transportation, classroom placement, etc.) and allows us to hopefully begin the enrollment process. You will be contacted shortly after we receive this application.

If you have any questions about Early Head Start, Head Start, or the application, please call us at **(740) 373-3745** and we will be glad to answer any questions.

### Part 1 Please choose an option for your child's participation in Early Head Start.

**CENTER**

I would like my child to attend a center in:

- Morgan County
- Washington County

**IN-HOME**

I would like my child to attend an In-Home Provider in:

- Morgan County
- Washington County

### Part 2 Please complete the following:

Has this child been in Early Head Start before?

- YES  NO

Child's name \_\_\_\_\_

Age \_\_\_\_\_

Date of birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Living at home?  YES  NO

Father's Name: \_\_\_\_\_

Living at home?  YES  NO

Your phone number: (     ) \_\_\_\_\_

If no phone,

message number: (     ) \_\_\_\_\_

Your address:

Street  
Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

If your home is not within the city limit, give a brief description:

Total number of children in the family, including child to be enrolled: \_\_\_\_\_

Ages of children: \_\_\_\_\_

Date of child's last healthcheck or physical \_\_\_\_\_

Date of child's last dental visit \_\_\_\_\_

Does child receive services from other agencies?  YES  NO

If so, which agencies? \_\_\_\_\_

Does the child receive SSI?  YES  NO

## Part3

**It is very important that you complete the following information.  
We are an income based program and we need your exact income from last year.**

My income for last year was \$ \_\_\_\_\_

I have an active Ohio Medicaid/Healthy Start Card  YES  NO

I receive Ohio Works First-TANF.  YES  NO Amount received monthly \$ \_\_\_\_\_

Because we are an income-based program, we need your exact income from last year. Please attach copies (no originals) of forms that provide proof of your total household income. Proof of income can be presented through 1040 tax forms, W-2 forms, statements from employers, Social Security, and/or child support documents.

I certify that the above income information is correct and I have attached copies of my proof of income:

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Signature

Date