THE COMMUNITY ACTION PROGRAM CORPORATIONOF WASHINGTON-MORGAN COUNTIES, OHIO (740) 373-3745
P.O.BOX 144 ,MARIETTA, OHIO 45750 DAVID E.BRIGHTBILL EX. DIRECTOR

Early Head Start

Pregnant Women Application

Community Action Early Head Start program is a free service for income eligible pregnant women and children from birth to three (3) years of age. The mission of this program is to assist young families to move towards self-sufficiency by providing high quality care and to collaborate with all community agencies to give each participating family the services and support they need to develop into strong, knowledgeable, self- sufficient families.

The Community Action Early Head Start Program will provide enrollment to income eligible families regardless of race, creed, color, national origin or disability.

The Community Action Early Head Start Program will include these free services for you and your child:

- Assistance in helping prepare for newborns arrival.
- Ways to help parents learn about fetal development.
- Information about other community services.
- Home base visits that support nutrition, birthing, and family planning.
- Assistance to ensure ongoing prenatal care.
- *To ensure accuracy in processing, please complete all of the questions on this application.*

If you have any additional questions regarding Early Head Start, please call

- Craig Gibbs (740) 373-3745

Office Use Only

Date Received _____ Staff Initials: _____

In-person Interview _____

EARLY HEAD START PREGNANT WOMEN APPLICATION

205 Phillips Street, Marietta, Ohio 45750 (740) 373-3745
320 South Main Street, Malta, Ohio 43758 (740) 962-3792

I. Please complete all of the following information.

Have you ever participated in Early Head Start before? Yes No
Pregnant Women's Name: _____
Expectant Father's Name: _____
Pregnant Women's- Age: _____ Date of Birth: _____
Due Date:_____ I'm having a: Boy Girl Unknown
Address:_____
Telephone: _____
If no phone, message number:_____
If your home is not within city limits, please give a brief description of location:_____
Will you need daycare upon the arrival of your newborn? Yes No

II. Please complete all of the following information.

family members in household: ____# adults living in the home: ____
Age of children: _____
Do you receive ongoing prenatal care? _____
If so, please name your Dr.: _____
Date of last prenatal visit: _____Date of last dental visit: _____
Do you have a disability? Yes No
Do you receive the Ohio Medicaid/Healthy Start card? Yes NO

Are you or your children (check all that apply):

- In emergency or transitional housing
- Residing in a motel or campground
- Doubled up or staying with friends or family due to economic hardship
- Staying in a car, park or public area
- Sleeping in an area that is not designed for, or ordinarily used as a regular sleeping space (office, dining room, basement or attic)

III. It is very important that you complete the following information and attach a copy of your income. We cannot process this application without income verification.

My income for last year was: $_____
I receive Ohio Works First/TANF- Amount per month:$_____

Because we are an income based program, we need exact income from last year. Please attach copies for your total household income. Proof of income may include- W-2, 1040 Tax Forms, Statement from Employer, Pay Stubs, Social Security, Child Support, and/or TANF.

I certify that the above information on this application is true and correct. If my family is found to be over the income guidelines, I understand I will be placed on an over-income waiting list, which does not guarantee placement. I also understand that completing this application **DOES NOT AUTOMATICALLY ENROLL ME IN THE EARLY HEAD START PROGRAM.** Notification or denial of enrollment will follow at a later date.

_____

Pregnant Women's Signature **Date**

IV. How did you hear about Early Head Start? Please let us know by circling all that applies!

Friend/Family Flier Newspaper Internet Head Start Employee Other:_____