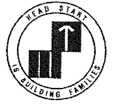


P.A.C.E. EARLY HEAD START PROGRAM

32 MADISON ST.
NEW BEDFORD, MA 02740
(508) 999-1286
www.paceheadstart.org

APPLICATION

APPLICANT INFORMATION

___ EXPECTANT MOTHER (___1st; ___2nd; ___3rd TRIMESTER)   ___ INFANT (0-15 mths)   ___ TODDLER (15 mths to 2.9 yrs)

NAME OF APPLICANT____
Last   First   Middle

DATE OF BIRTH ______________ MALE ___ FEMALE ___ SOCIAL SECURITY# ______________

PRIMARY LANGUAGE ____________________OTHER LANGUAGES SPOKEN______________

WHICH OF THE FOLLOWING BEST DESCRIBES THE APPLICANT'S ETHNICITY AND RACE?

ETHNICITY:
Hispanic or Latino Origin ___
Non-Hispanic or Non-Latino Origin ___

RACE:
American Indian or Alaska Native ___ Asian ___ White___
Native Hawaiian or other Pacific Islander___
Black or African American ___ Biracial/Multi-racial ___ Unspecified___
Other___ Please explain: ______________________________

FAMILY INFORMATION

HEAD OF HOUSEHOLD NAME:__________ ______________ ______________
Last   First   Middle

DATE OF BIRTH______________ MALE____FEMALE____ SOCIAL SECURITY# ______________

PRIMARY LANGUAGE ____________________OTHER LANGUAGES SPOKEN______________

ADDRESS________________________________ FLOOR AND APT # ______________

CITY________________ ZIP CODE____________HOME PHONE: ______________

CELL PHONE: ______________ E-MAIL ______________________________

PHONE & NAME OF RELATIVE/FRIEND FOR MESSAGE ______________________________

NAMES OF OTHER FAMILY / HOUSEHOLD MEMBERS:

ADULTS: ________________DATE OF BIRTH________SOCIAL SECURITY # ______________
________________ ________ ______________
________________ ________ ______________

CHILDREN________________ DATE OF BIRTH________SOCIAL SECURITY #______________
________________ ________ ______________
________________ ________ ______________

TOTAL HOUSEHOLD SIZE ________

REFERRAL INFORMATION

HOW DID YOU HEAR ABOUT HEAD START? ____

WITH WHAT OTHER AGENCIES ARE YOU OR YOUR CHILD CURRENTLY INVOLVED? ____________________
____

FOR EXPECTANT MOTHERS

DO YOU HAVE ANY CONCERNS ABOUT YOUR PREGNANCY ? ____
____

HAS YOUR DOCTOR OR OTHER PROFESSIONAL DIAGNOSED YOU AS HAVING A MEDICAL CONCERN/ISSUE DURING PREGNANCY? Yes____ No_____ (High Risk Pregnancy; High Blood Pressure; Heart Disease; Diabetes; STD's; History of Substance Use; Smoker: Other risks…) Please Explain: ____
____

FOR INFANTS/TODDLERS

HAVE THERE BEEN CONCERNS ABOUT THE CHILD'S DEVELOPMENT (Vision, Hearing, Speech, Walking, Other) ?
____

HAS A DOCTOR OR OTHER PROFESSIONAL EVER DIAGNOSED THE CHILD AS HAVING A SPECIAL NEED OR DISABILITY? Yes____ No_____ Explain: ____
____

DOES THE CHILD HAVE EARLY INTERVENTION SERVICES AT THIS TIME? Yes______ NO______
WITH WHICH PROGRAM IS THE CHILD INVOLVED? ____

HOUSING SITUATION

OWN HOME ______ PUBLIC HOUSING______ RENTED APARTMENT______ SECTION 8 RENTAL ______

SHELTER______ LIVE WITH RELATIVES______ OTHER: ____

HAVE YOU AND YOUR FAMILY BEEN HOMELESS IN THE LAST 6 MONTHS? Yes______ No______

PLEASE, EXPLAIN: ____

HOUSEHOLD INCOME

TANF $ ___________ SSI $___________ CHILD SUPPORT $___________ FOSTER CARE PAYMENT $ ___________
UNEMPLOYMENT $ ____________ WEEKLY WAGES (GROSS INCOME BEFORE TAXES) $ ____________________
OTHER $ ______________________________TOTAL AMOUNT PER MONTH $ ____________________________
WHO RECEIVES INCOME? ____

DID YOU OR YOUR FAMILY RECEIVE PUBLIC ASSISTANCE (TANF/SSI) IN THE PAST YEAR?
YES____ NO ____

HAS THERE BEEN (or will there be) ANY CHANGE IN INCOME IN THE PAST (or the next) 6 MONTHS?
YES______ NO_______ EXPLAIN: ____

IS YOUR FAMILY RECEIVING ANY OF THESE SERVICES?
WIC___________________ SNAP BENEFITS (FOOD STAMPS) $________________ MASS HEALTH ________________

EMPLOYMENT

FAMILY MEMBER	EMPLOYED AT	WORK SCHEDULE	HOURS PER WEEK
________________	______________	__________________	_________________
________________	______________	__________________	_________________

EDUCATION/TRAINING

CURRENT EDUCATION LEVEL: SOME HIGH SCHOOL ___HIGH SCHOOL DIPLOMA/GED ___ SOME COLLEGE ___ ASSOCIATE"S DEGREE ___ BACHELOR"S DEGREE ___ TRADE SCHOOL ___MILITARY/SERVICE ___ OTHER ___

ARE YOU CURRENTLY ENROLLED OR PLANNING TO ENROLL IN AN EDUCATION OR TRAINING PROGRAM?
YES ____ NO ____ NAME OF PROGRAM________________________________ DATE OF ATTENDANCE ________

FAMILY NEEDS

P.A.C.E. HEAD START PROVIDES A VARIETY OF SUPPORT SERVICES TO HELP FAMILIES. PLEASE CHECK ANY CONCERNS WITH WHICH YOU NEED ASSISTANCE.

LACK OF RESOURCES:
Inadequate income, housing, child care, ________
transportation, food, clothing ________
EDUCATION/ EMPLOYMENT
Reading/writing skills, learning disability ________
English as a second language ________
Lack of education/training ________
CUSTODY ISSUES ________
NEIGHBORHOOD SAFETY ________
FAMILY VIOLENCE ________
DENTAL/PHYSICAL HEALTH ISSUES ________
MENTAL HEALTH ISSUES ________
FAMILY SUPPORTS ________
Recent move to area, few local family/friends ________
Not involved in agencies/groups ________

PLEASE TELL US IF THERE ARE ANY SPECIAL CIRCUMSTANCES (i.e. change in guardianship, special need of child) THAT WE SHOULD CONSIDER TO, DETERMINE YOUR CHILD'S ELIGIBILITY FOR THIS PROGRAM:
____
____
*IF YOU WOULD LIKE TO PERSONALLY DISCUSS YOUR CIRCUMSTANCES PLEASE CALL AND ASK TO SPEAK WITH A FAMILY ADVOCATE OR THE FAMILY SERVICES MANAGER.

TRANSPORTATION

CAN YOU TRANSPORT YOURSELF/YOUR CHILD TO AND FROM SCHOOL? YES ______ NO ______

IF YOU HAVE NO TRANSPORTATION AND MUST USE HEAD START'S SERVICES, YOUR CHILD MAY BE BUSSED FROM A CORNER STOP NEAR YOUR HOME. TO HELP US PLAN, WHAT IS THE CLOSEST CORNER?
____and ____________________________________
Name of Street, Avenue, Boulevard or Court Name of Street, Avenue, Boulevard or Court

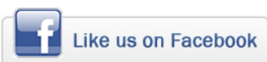
HEAD OF HOUSEHOLD SIGNATURE ______________________________DATE______________________

RELATIONSHIP TO CHILD: ____

TOILET TRAINING STATUS IS NOT AN ELIGIBILITY REQUIREMENT FOR ENROLLMENT.

According to Public Law # 92-261 no child shall be discriminated against because of RACE, RELIGION, CULTURAL HERITAGE, POLITICAL BELIEFS, MARITAL STATUS, DISABILITY, SEXUAL ORIENTATION OR NATIONAL ORIGIN.

P.A.C.E. Head Start is funded by the Administration for Children and Families and the Massachusetts Department of Early Education And Care and operates in accordance with Head Start Performance Standards. The Head Start Program is licensed by the Massachusetts Department of Early Education and Care and is accredited by the National Association for the Education of Young Children.



Clicking the submit button generates a draft message in your email account. Please open the draft and click send to complete your application.