If you have questions concerning completion of this application, contact your local Head Start Center of Central Office.

CSRA EOA, Inc. Head Start

1261 Greene Street
P.O. Box 10104
Augusta, Georgia 30903-2704
706-722-0493

PLEASE DO NOT WRITE IN THIS BOX

ChildPlus ID# _____

RECRUITMENT APPLICATION

Child's Legal Name: Last First M.I		
2. Date of Birth	3. Child's Social Security Number	4. Race/Ethnicity
5. Is child a relative of any Head Start staff ____Yes _____ No_____ If Yes, give name(s), relationship, and department:_____		6. Sex: Male or Female
8. Address City State Zip Code County		
Direction to home		
9. Telephone Number: Home: (____)_____ Cell: (____)_____ Message: (____)_____ Email:_____		
10. Mother's Name (lives with Child ____Yes ____No) Date of Birth: _____ Social Security Number:_____		11. Physical Address
12. City State Zip County		13. Telephone Number: Home_____ Message_____
14. Father's Name (lives with Child ____Yes ____No) Date of Birth: _____ Social Security Number:_____		15. Address
16. City State Zip County		17. Telephone Number: Home_____ Message_____
18. Legal Guardian (lives with Child ____Yes ____No)		19. Address
20. City State Zip County		21. Telephone Number: Home_____ Message_____
22. Does your child need transportation? _____Yes _____No How many miles?_____ (Subject to change)		
23. Is your child currently attending a child development center? ___ Yes ____ No Name of Day Care:_____ Phone Number:_____ Address:		

24. Are you on TANF?	Yes_____	No_____	TANF No:_____
Previous TANF participant	Yes_____	No_____	
Are you on WIC?	Yes_____	No_____	WIC No:_____
Are you on SSI?	Yes_____	No_____	
Is your child on SSI?	Yes_____	No_____	Child's Name:_____
Is your child on SNAP?	Yes_____	No_____	
Are you in the Military?	Yes_____	No_____	
Are you a veteran?	Yes_____	No_____	

25. Was child referred to the Program? ____Yes _____No What agency?_____

By Whom? _____

26. Does your family/child have a medical home? ___Yes ___No

Does your family/child have a dental home? ___Yes ___No

Child's Medicaid/Private Insurance

Provider's Name_____

Number:_____

27. Language spoken at home_____

Language spoken by Child_____

28. Any specific family need or crisis? ____Yes ____No Are you homeless? (optional) ___Yes ___No

30. Health Issues: Asthma___ Allergy/Food Allergy____ Seizures_____ Heart Problems _____ Sickle Cell_____ Other____
(Doctor's verification required)

31. Does child have a suspected disability? ___Yes ___No

Doctor's Name_____ Diagnosis_____

Does your child have a diagnosed disability with an IEP? ___Yes ___No

Family Member Income

Adults	Annual Income	Source of Income	Education Level	Employment Status

Family Member Information

Children

Name	Relationship to Child	Sex	Date of Birth	Social Security Number

In order for this application to be processed the following information must be attached:

1. **Certified Birth Certificate**
2. **Verification of income** (W-2 form, copy of Tax Return, TANF/DFCS Summary notification, SSI, Security Benefits Letter, Dept. of Labor Four Quarter Print out, child Support)
3. **Immunization Certificate** (3231 Form)
4. **Social Security Card**
5. **Medicaid Card**

CERTIFICATION: I certify that this information is true. If any part is false, my participation in this agency's program may be terminated and I may be subjected to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible tome during normal business hours.

Parent/Legal Guardian Signature_____
Date_____

Signature of Verifying Staff Member_____

Date_____

Revised 1/2016