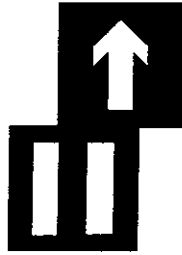




**Rockingham County**  
Governmental Center  
Wentworth, NC 27375



*Rockingham County*  
**HEAD START**  
705 Ayersville Road  
Madison, NC 27025  
(336) 349-4762  
Fax (336) 342-6634

## Request for Application

Dear Parent(s):

Thank you for your interest in enrolling your child into Rockingham County Head Start.

Children who meet the following requirements may enroll in the Rockingham County Head Start program:

- Child must reside in Rockingham County
- Child must be 3 years of age by August 31st

To apply for Head Start, you will need the following:

- Birth Certificate
- Shot/Immunization Records
- Medicaid/Other Insurance Verification
- Income verification ( W2's Forms, Tax Returns, Child Support, Work First, Disability, SSI, Financial Aid, etc).
- Custody Papers, Divorce Documentation, or any other legal documents relating to the child (if applicable).

Rockingham County Head Start is based on a point system. Income is only one portion of the point system. The child's age and family factors will also contribute to the child's total points.

Enclosed you will find an application should you have any questions please do not hesitate to call us at (336) 349-4762.

Thank you,  
Family Service Department

**Applicant & Family Member Information**

Applicant ( Childs name)						
First	Middle	Last	Suffix	Nickname	Birthday	Gender
Race		Hispanic	English Proficiency		Other Language	Other Language Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little			<input type="checkbox"/> Little
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate			<input type="checkbox"/> Moderate
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None			<input type="checkbox"/> None
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient			<input type="checkbox"/> Proficient
Primary Health Coverage		Other Coverage	Insurance #	Medicaid Eligibility	Medicaid #	Doctor/Medical Home
				<input type="checkbox"/> Not Eligible		
				<input type="checkbox"/> On Medicaid		
				<input type="checkbox"/> Potentially		
Dental Coverage		Dental Coverage #		Dentist/Dental Home		

Primary Adult						
First	Middle	Last	Suffix	Nickname	Birthday	Gender
Race		Hispanic	English Proficiency		Other Language	Other Language Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little			<input type="checkbox"/> Little
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate			<input type="checkbox"/> Moderate
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None			<input type="checkbox"/> None
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient			<input type="checkbox"/> Proficient
Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply
<input type="checkbox"/> Associate's	<input type="checkbox"/> Grade 10	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full Time & Training	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Lives with Family
<input type="checkbox"/> Bachelor's	<input type="checkbox"/> Grade 11	<input type="checkbox"/> Part Time	<input type="checkbox"/> Part Time & Training	<input type="checkbox"/> Biological/Adopted/Step	<input type="checkbox"/> No	<input type="checkbox"/> Provides Financial Support
<input type="checkbox"/> Col Deg/Train	<input type="checkbox"/> Grade 12	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Training	<input type="checkbox"/> Grandchild		<input type="checkbox"/> Teen Parent
<input type="checkbox"/> Col or Adv Train	<input type="checkbox"/> < Grade 9	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Training or School	<input type="checkbox"/> Other Relative		If teen parent, subsidized?
<input type="checkbox"/> GED	<input type="checkbox"/> HS Graduate		<input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Foster		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Master's			<input type="checkbox"/> Other		
Email Address: _____						

Secondary or Other Adult						
First	Middle	Last	Suffix	Nickname	Birthday	Gender
Race		Hispanic	English Proficiency		Other Language	Other Language Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little			<input type="checkbox"/> Little
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate			<input type="checkbox"/> Moderate
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None			<input type="checkbox"/> None
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient			<input type="checkbox"/> Proficient
Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply
<input type="checkbox"/> Associate's	<input type="checkbox"/> Grade 10	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full Time & Training	<input type="checkbox"/> Biological/Adopted/Step	<input type="checkbox"/> Yes	<input type="checkbox"/> Lives with Family
<input type="checkbox"/> Bachelor's	<input type="checkbox"/> Grade 11	<input type="checkbox"/> Part Time	<input type="checkbox"/> Part Time & Training	<input type="checkbox"/> Grandchild	<input type="checkbox"/> No	<input type="checkbox"/> Provides Financial Support
<input type="checkbox"/> Col Deg/Train	<input type="checkbox"/> Grade 12	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Training	<input type="checkbox"/> Other Relative		<input type="checkbox"/> Teen Parent
<input type="checkbox"/> Col or Adv Train	<input type="checkbox"/> < Grade 9	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Training or School	<input type="checkbox"/> Foster		If teen parent, subsidized?
<input type="checkbox"/> GED	<input type="checkbox"/> HS Graduate		<input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Other		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Master's					
Email Address: _____						

Additional Child (Non-Applicant) *						
First	Middle	Last	Suffix	Nickname	Birthday	Gender
Race		Hispanic	English Proficiency		Other Language	Other Language Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little			<input type="checkbox"/> Little
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate			<input type="checkbox"/> Moderate
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None			<input type="checkbox"/> None
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient			<input type="checkbox"/> Proficient

Additional Child (Non-Applicant) *						
First	Middle	Last	Suffix	Nickname	Birthday	Gender
Race		Hispanic	English Proficiency		Other Language	Other Language Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little			<input type="checkbox"/> Little
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate			<input type="checkbox"/> Moderate
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None			<input type="checkbox"/> None
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient			<input type="checkbox"/> Proficient

\* Items needed: Birth certificate, Shot records, Insurance card, Income (Tax returns W2's, Child support, Work first, SSI, etc.)

# Family Information, Income & Contacts

## Family Information

Family Living Address  
 Started Living At Date Living Address Address Line 2 ZIP City State County

Family Mailing Address  
 Same as living? Started Using Date Mailing Address Address Line 2 ZIP City State

Yes  No

Phone Number(s) Type (check one) Note (extension or best time to call) Opt in for Text Messages

Cell  Home  Work  Other  Yes  No

Cell  Home  Work  Other  Yes  No

Cell  Home  Work  Other  Yes  No

Parental Status (check one) Primary Language at Home Homeless Family Active Duty Military Retired by Child Welfare Agency Receiving SNAP WIC WIC ID (if applicable)

One  Two  Yes  No  Yes  No  Yes  No  Yes  No  Yes  No

## Family Income

Income Verified by Verification Date TANF Status SS

Yes  No  Formerly on TANF/Not now  Yes  No

Family Member	Amount	Pay for example week-month-year	Annual Amount	Description (for example SS, job, Child Support)	Verification (for example 1/2, check stub)	Note
	\$		\$			
	\$		\$			
	\$		\$			

Income Notes

## Emergency Contacts

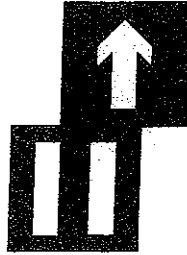
Name	Relationship	Emergency Contact	Release To
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Address ZIP City State			
Phone Number 1 <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work			
Phone Number 2 <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work			
Phone Number 3 <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work			
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Address ZIP City State			
Phone Number 1 <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work			
Phone Number 2 <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work			
Phone Number 3 <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work			
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Address ZIP City State			
Phone Number 1 <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work			
Phone Number 2 <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work			
Phone Number 3 <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work			

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

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



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 Governmental Center  
 Wentworth, NC 27375



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**HEAD START**  
 705 Ayersville Road  
 Madison, NC 27025  
 (336) 349-4762  
 Fax (336) 342-6634

\_\_\_\_\_  
 Child's Name

\_\_\_\_\_  
 Center

I, \_\_\_\_\_ give my permission for  
 \_\_\_\_\_ to release information to the Rockingham  
 County Head Start program. This information is to be used only as verification of income for  
 enrollment purposes in the Head Start program.

Applicant's Signature \_\_\_\_\_

Address \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

Caseworker/Contact person \_\_\_\_\_

Benefit or Salary amount received from \_\_\_\_\_ to \_\_\_\_\_

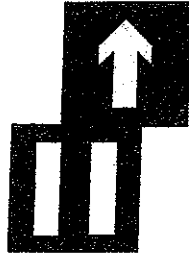
\_\_\_\_\_  
 \_\_\_\_\_

Caseworker/Contact person signature \_\_\_\_\_

Date \_\_\_\_\_



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**AUTHORIZATION TO RELEASE INFORMATION**

Parent's Name: \_\_\_\_\_

Child(ren)'s Name: \_\_\_\_\_

I understand that the State of North Carolina has created a system that combines limited information about children and families who receive services from publicly-funded programs like the Head Start and Early Head Start programs into a single, statewide system called the NC Early Childhood Integrated Data System (NC ECIDS)

I understand that the purpose of NC ECIDS is to help provide answers to important policy and program questions about publicly-funded programs administered in North Carolina; as well as those questions that my local Head Start or Early Head Start program may have about the services offered in the county(ies) in which it operates.

I understand that NC ECIDS is requesting my permission to receive the following information about my child(ren) and family to be included in NC ECIDS:

- |                       |                                    |
|-----------------------|------------------------------------|
| Child's Name*         | Primary Language                   |
| Child's Date of Birth | Category of Enrollment Eligibility |
| Child's Gender        | Health Insurance Status            |
| Child's Race          |                                    |

*\*I understand that my child's name will never be released publicly in any report*

I understand that allowing data about my child(ren) and family to be released to NC ECIDS is voluntary and is not a requirement for my child to be enrolled in the Head Start or Early Head Start Program.

\_\_\_\_\_ I authorize Rockingham County Head Start to release the information about my child(ren)/family noted above to NC ECIDS

\_\_\_\_\_ I DO NOT authorize Rockingham County Head Start to release the information about my child(ren) family noted above to NC ECIDS

*Please sign on the back*

**ROCKINGHAM COUNTY HEAD START  
RESIDENCY FORM**

The purpose of this form is to determine the extent to which the family is living in a fixed, regular and adequate living situation.

**Child's Name:** \_\_\_\_\_

**Fixed: Stationary, Permanent, and not Subject to Change**

1. Is this a permanent or temporary arrangement?     Permanent     Temporary
2. How long do you plan on living with friends/family? \_\_\_\_\_
3. Are you looking for another place to live?     Yes     No
4. Why are you staying in your current place? \_\_\_\_\_  
\_\_\_\_\_

**Regular: Used on a Regular Basis (Example, Nightly)**

5. Do you stay in the same place every night?     Yes     No
6. Do you have a key to the place where you are living?     Yes     No
7. Do you move around a lot?     Yes     No
8. How long have you been living in your current place? \_\_\_\_\_

**Adequate: Sufficient for Meeting Both the Physical and Psychological Needs Typically met in Home Environments**

9. How many people are living in the home? \_\_\_\_\_
10. How many bedrooms and bathrooms does it have?    \_\_\_\_\_ Bedrooms    \_\_\_\_\_ Bathrooms
11. Does every family member have his or her own bed to sleep in?     Yes     No
12. Are you and your children sleeping in a bedroom or somewhere public like a living room?  
       Bedroom     Public Space: \_\_\_\_\_
13. Does the home have heat, electricity and running water?     Yes     No

**The family's living situation is:**     Fixed     Regular     Adequate

**Staff Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# Rockingham County Head Start Child Emergency and Medical Information

Name of Child \_\_\_\_\_ Birthdate \_\_\_\_\_

Name of Parent or Guardian \_\_\_\_\_

Address of Parent of Guardian \_\_\_\_\_

Cell phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

If parent cannot be contacted call:

Name \_\_\_\_\_ Phone number \_\_\_\_\_

Name \_\_\_\_\_ Phone number \_\_\_\_\_

## In Case of Emergency

Hospital Preference	Address	City	State	Phone number
---------------------	---------	------	-------	--------------

Physician Preference	Address	City	State	Phone number
----------------------	---------	------	-------	--------------

## Health Care Needs

1. Is child allergic to anything? No \_\_\_ Yes \_\_\_ If yes, what? \_\_\_\_\_

2. Is child currently under a doctor's care? No \_\_\_ Yes \_\_\_ If yes, for what reason? \_\_\_\_\_

3. Is the child on any continuous medication? No \_\_\_ Yes \_\_\_ If yes, what? \_\_\_\_\_

4. Any previous hospitalizations or operations? No \_\_\_ Yes \_\_\_ If yes, when and for what? \_\_\_\_\_

5. Any history of significant previous diseases or recurrent illness? No \_\_\_ Yes \_\_\_

Diabetes No \_\_\_ Yes \_\_\_; Convulsions No \_\_\_ Yes \_\_\_; Heart trouble No \_\_\_ Yes \_\_\_

Asthma No \_\_\_ Yes \_\_\_; Seizures No \_\_\_ Yes \_\_\_ If others, what/when? \_\_\_\_\_

6. Does the child have any physical disabilities: No \_\_\_ Yes \_\_\_ If yes, please describe: \_\_\_\_\_

7. Any mental disabilities? No \_\_\_ Yes \_\_\_ If yes, please describes: \_\_\_\_\_

8. Any particular fears or behavior characteristics the child has? No \_\_\_ Yes \_\_\_ If yes, please describes: \_\_\_\_\_

9. Other Important Information \_\_\_\_\_

I, the undersigned parent/guardian, hereby give my consent, in the event of an emergency where neither I nor my family physician can be contacted for the above named child to be taken to the hospital I have named above or to the emergency room at the nearest hospital for treatment by the physician in the emergency room.

I, hereby consent to having this information on this sheet available in the Head Start classroom or on vehicles used to transport my child to/from Head Start Activities.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_