



**San Francisco State University**

San Francisco Head Start/ Early Head Start

205 13<sup>th</sup> Street, Suite 3280 , San Francisco, California 94103 (415)-405-0500

**Enrollment Application**

**APPLICANT (PREGNANT WOMAN OR CHILD) AND FAMILY INFORMATION**

Applicant Last Name:		First Name:		Preferred Name (Nickname):	
<b>Race:</b> B = Black/African-American W = White A = Asian BM=Biracial/Multiracial N = American Indian or Alaskan Native P = Native Hawaii/ Other Pacific Islander O=Other					
<b>Ethnicity:</b> I. Hispanic or Latino Origin <input type="checkbox"/> II. Non-Hispanic/Non-Latino <input type="checkbox"/>					
Applicant's Social Security #:		Sex: (circle one) F = Female M = Male		Date of Birth:	
Applicant's Language (s):		Parent/Guardian Language(s) (Complete if applicant is a child)			
Address:				City/State: San Francisco, CA	
Zip Code:		Phone: <input type="checkbox"/> Home <input type="checkbox"/> Message:		Other Phone:	
Parental Status: (circle one) O = Single Parent T = Two Parents F = Foster N = Not Child's Parent D=Joint Custody same household two separate households					
Number in Family:		Number of Children in Family: _____ by Age: 0-3_____ 4-5_____		(EHS) Pregnant Mothers: Due Date _____	
<b>Type of Health Insurance:</b> <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Healthy Families <input type="checkbox"/> None <input type="checkbox"/> Private (Name): _____ Health Insurance # _____			Primary Physician Name/ #: _____ Dentist's Name/ #: _____		
How did you hear about Head Start? <input type="checkbox"/> family <input type="checkbox"/> friend <input type="checkbox"/> media <input type="checkbox"/> other: _____				Does child have a disability or special needs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Suspected	
Housing: <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Public <input type="checkbox"/> Homeless				Does you child currently have a diagnosed medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state condition: _____	

**FAMILY MEMBER INFORMATION**

List family members living in household who are financially supported by parent or guardian of the applying child and are related by blood, marriage or adoption.

**GREY AREAS - STAFF USE ONLY**

**ADULTS**

CODE	First and Last Name Enter Primary Adult First	Date of Birth	Social Security #	Sex	(D1) Edu Status	(D2) Empl Status	Occupation
A 01				M F			
A 02				M F			
A 03				M F			
D1 – Education years completed (insert codes in the section above marked D1)  G09 = Grade 9 or less HSG = High School Graduate G10 = Grade 10 GED = GED G11 = Grade 11 COL = Some College, advanced training or Associates Degree G12 = Grade 12 B= Bachelor's Degree or Higher					D2 – Employment status (insert codes in the section above marked D2) F = Full-time (35 or more hours per week) P = Part-time (less than 35 hours per week) S = Seasonally employed U = Unemployed T = In training or school R = Retired or Disabled		

**CHILDREN (For Pregnant Women applying for Early Head Start, include unborn child & estimated DOB)**

CODE	First and Last Name of the Child Enter Applicant First	Date of Birth	Social Security #	Sex	(D1) Child is related to	(D2) This child is	Participation Status
C01				M F			A N Y O
C02				M F			A N Y O
C03				M F			A N Y O
C04				M F			A N Y O
C05				M F			A N Y O
D1 – Child is related to: (insert codes in the section above marked D1) A01 = First adult A02 = Only the second adult B01 = Not related B12 = Both adults		D2 – This child is: (insert codes in the section above marked D2) C = Natural or adopted child (includes stepchild) F = Foster child N = Niece or nephew G = Grandchild O = Other			Participation Status A = Applicant (child who is currently applying) N = Child too young but will be eligible next year Y = Child too young to be eligible next year O = Child too old for Head Start program		

**STATE PRESCHOOL SITES ONLY**

**Certification and signature of parent caretaker**

1. I declare under penalty of perjury that the information provided is true and correct to the best of my knowledge.
2. I will notify the agency immediately if there is any change in my income, family size, residence, employment, or reason for needing child development services.
3. I understand that the information about my eligibility may be reviewed by representatives of the State of California, the Federal Government, independent auditors, or others as necessary for the administration of the program.
4. I understand that if the agency denies this application for services, I have the right to appeal.
5. I understand that I must renew my eligibility at least once per year (at least once every six months for children receiving CPS). I further understand that if I do not renew my eligibility, I will no longer be eligible for subsidized services for my child.
6. I understand that I will receive a notice of approval or disapproval of my application within 30 days from the date I sign this form.
7. I understand that this certification is not complete until all documentation is submitted and this form has been reviewed, signed, dated by an agency representative and signed and dated by me.

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

Relationship To Child:     Parent     Grandparent     Guardian     Foster Parent     Other: \_\_\_\_\_

<b>Staff Only:</b> Eligibility Status:  <input type="checkbox"/> Accepted <input type="checkbox"/> Denied	Date Notice of Action Sent: (Attach Copy)	First Date of Enrollment:
	Date Notice of action Given (part 2): (Attach Copy)	Last Date of Enrollment:

**Please choose a Center Location from the list on the back of the application**

**In addition to the completed application we will need:**

1. Income Verification (Please attach one of the following documents.)/to reflect the past twelve months or calendar year
  - ✓ Public Assistance Verification Letter (AFDC, TANF/Calworks, or SSI)
  - ✓ Pay Stubs
  - ✓ Verified Letter from Employer
  - ✓ Unemployment Compensation (Claim letter or payment stubs)
2. Verification of Child's Age
  - ✓ Birth Certificate
  - ✓ Passport
  - ✓ Medi-Cal card
3. Proof of San Francisco City and County Residency
  - ✓ Utility Bill (PG&E, Cable, SBC)
  - ✓ Current Rental Agreement or Lease
4. Child's Immunization Records
5. Current Physical/Medical Exam and Dental Exam (If available)

**I declare under penalty of perjury that the above information is true and correct to the best of my knowledge.**

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

- All applications determined to be overincome will be shared with the San Francisco CEL Program.
- All State Preschool Site Waiting Lists\* will be shared with the San Francisco CEL Program

***Thank you for applying to the San Francisco Head Start /Early Head Start program.***

**STAFF USE ONLY**

**PROGRAM INFORMATION**

School Year: 2007-2008		2008-2009	
<b>(Please Circle)</b>			
Program Code: H = Head Start    D = State Preschool P = Early Head Start		Program Description: SF = Full Day FC = Family Child Care HB = Home Based	
Application Status: C = Application complete and verified M = Application complete; needs medical information I = Application incomplete; several items missing B = Application complete; needs birth certificate V = Application complete; needs income verification		Age by Dec. 2 <sup>nd</sup> (of year applying): 3 years old 4 years old Infant/toddler age _____ mos.	
Center/Home Visitor Name:		Location ID:	
Class ID:			

**ELIGIBILITY INFORMATION (Please Circle or Complete)**

Child Eligible Next Year:    Y = Yes    N = No		Sibling Eligible Next Year?    Y = Yes    N = No	
TANF (AFDC)    Y = Yes    N = No SSI    Y = Yes    N = No			
Income Status:    E = Eligible    O = Over-income    P = Public Assistance F = Foster		Disability Status:    Z = None    X = Suspected	
Eligibility Comments:			
Family Annual Gross Income:			
<b>(MIS/IT Staff Only)</b>		<b>Staff Name</b>	
<b>Date:</b>		<b>Appl #:</b>	
		<b>Famseq#:</b>	

**ELIGIBILITY WORKSHEET**

<b>Age Documentation:</b>				
<input type="checkbox"/> Birth Certificate		Date of Birth: _____		
<input type="checkbox"/> Other _____				
<b>Income Documentation:</b>				
<i>Check one or more</i>				
<input type="checkbox"/> Pay Stubs				
<input type="checkbox"/> *Letter from DHS, AFDC, TANF* Case# _____		Date: _____		
<input type="checkbox"/> Supplemental Social Security Income				
<input type="checkbox"/> Unemployment Compensation				
<input type="checkbox"/> Income Tax Form 1040A or 1040, for year _____		(Self Employed Only)		
<input type="checkbox"/> Other, specify _____				
Comments _____				
<b>INCOME (list all applicable adults in household)</b>				
Family Member	Pay Stub Total (Gross)	Average Total	Multiply (X) by	Annual Family Income
A.	1. \$ _____ 2. \$ _____ 3. \$ _____ + = _____	÷ pay stub total by the number of pay stubs Avg. Total:	<input type="checkbox"/> 52 (Weekly) <input type="checkbox"/> 26 (Every 2 wks) <input type="checkbox"/> 24 (Twice a mnth) <input type="checkbox"/> 12 (Monthly)	\$ _____
B.	1. \$ _____ 2. \$ _____ 3. \$ _____ + = _____	÷ pay stub total by the number of pay stubs Avg. Total:	<input type="checkbox"/> 52 (Weekly) <input type="checkbox"/> 26 (Every 2 wks) <input type="checkbox"/> 24 (Twice a mnth) <input type="checkbox"/> 12 (Monthly)	\$ _____
C.	1. \$ _____ 2. \$ _____ 3. \$ _____ + = _____	÷ pay stub total by the number of pay stubs Avg. Total:	<input type="checkbox"/> 52 (Weekly) <input type="checkbox"/> 26 (Every 2 wks) <input type="checkbox"/> 24 (Twice a mnth) <input type="checkbox"/> 12 (Monthly)	\$ _____
Please use an additional worksheet as needed and if the child lives in two homes.				





# San Francisco Head Start/ Early Head Start

## Grantee Operated Centers/Programs for 2007-2008

Please mail or drop off your application directly to the center you are interested in attending or our Central Office. If you have any questions, feel free to call any of the Centers listed below. A Head Start/Early Head Start staff will be pleased to help you fill out the application or answer any questions.

<p><b>Aleman Head Start</b> 956 Ellsworth Street San Francisco, CA 94110 415-826-9548 phone</p>	<p><b>OMI Head Start</b> 1111 Junipero Serra Blvd. San Francisco, CA 415.337.0221 phone 415.585.0433 fax</p>
<p><b>Cadillac Head Start</b> 316 Leavenworth San Francisco, CA 94102 415.447.1384 phone 415.776.0365 fax</p>	<p><b>Potrero Hill Head Start</b> 824 Carolina Street San Francisco, CA 415.821.6639 phone 415.821.6540 fax</p>
<p><b>Children’s Village Head Start</b> 250 10<sup>th</sup> Street San Francisco, CA 94103 415-552-8467</p>	<p><b>Southeast Head Start</b> 1300 Phelps Street San Francisco, CA 415.821.6005 phone 415.647.7473 fax</p>
<p><b>Ella Hill Hutch Head Start</b> 1050 McAllister San Francisco, CA 415.885.6547phone 415.885.6187 fax</p>	<p><b>Sunnydale Head Start</b> 1652 Sunnydale Avenue San Francisco, CA 94134 415-337-8407 phone 415-337-7409 fax</p>
<p><b>Hunter’s View Head Start</b> 125 West Point Road San Francisco, CA 415.824.4686 phone 415.824.4656 fax</p>	<p><b>Westside Head Start</b> 2400 Post Street San Francisco, CA 415.474.7637 phone 415.474.7430 fax</p>
<p><b>Kirkwood Head Start /Early Head Start</b> 729 Kirkwood San Francisco, CA 94124 Phone Number (TBD)</p>	<p><b>Early Head Start – (Home Base Option)</b> 205 13<sup>th</sup> Street Suite 3280 San Francisco, California 94103 For more information on this program, call, 415-405-0500 Service Areas: Bayview/ Hunter’s Point, Western Addition, OMI, Treasure Island</p>
	<p><b>Family Child Care Program – Head Start</b> Locations in Bayview/Hunter’s Point, Visitacion Valley, Haight, OMI, Excelsior, Sunset and Richmond. For more information on this program, call 415.405.0500</p>