Department of Education
Guam Head Start Program
APPLICATION (Part One)

FOR OFFICAL USE ONLY Center: _____Application Number: _____

CHILD INFORMATION – Child's name MUST reflect birth certificate for documentation purposes.

Child's Legal Name (Last)	(First and Middle Initial)	Date of Birth	Sex	Social Security #

Mailing Address:

City State Zip Code

Citizenship: [ ]U.S. Citizen [ ]FSM Citizen [ ]Belau Citizen [ ] Resident Alien [ ]Non-Resident

Ethnicity (check ALL that apply): [ ]American Indian/Alaskan [ ]Asian [ ]African American [ ]Caucasian [ ]Hispanic
[ ]Pacific Islander [ ]Other(s) – Specify:_____

Child's PRIMARY Language: **Family's PRIMARY Language:**

HOUSEHOLD PARENT/GUARDIAN INFORMATION

First and Last Name	DOB	Ethnicity	Highest Grade Completed	Diploma/GED /NA	Occupation	Full/Part Time
[ ]**Mother** [ ]Guardian [ ]CPS [ ]Foster [ ]Not in Household						
Contact Information H /C /W /e-mail _____						
[ ] **Father**[ ] Guardian[ ] CPS [ ] Foster [ ]Not in Household [ ]In Birth Certificate						
Contact Information H /C /W /e-mail _____						

Marital Status: [ ]Single [ ]Married [ ]Divorced [ ]Separated [ ]Widowed [ ]Common-Law

Family's Primary Contact Person for Head Start (MUST be listed above): _____

Number in Family: _____ Are you a former Head Start parent? [ ] Yes [ ] No

OTHER MEMBERS IN HOUSEHOLD SUPPORTED BY THE PARENTS AND GUARDIANS

First and Last Name	DOB	Relation to child: brother, sister, etc.	First and Last Name	DOB	Relation to child: brother, sister, etc.

CHILD'S SPECIAL NEEDS INFORMATION

Disability Status: [ ]None [ ] Suspected/Concern – Specify below
[ ] **Diagnosed** – Attach signed consent and related document (Current IEP)

Concerns about your child's development- check all that apply: [ ] None [ ]Vision [ ]Developmental [ ]Hearing [ ]Speech
[ ] Behavior [ ]Other_____

Do you want your child referred for further evaluation? [ ]No [ ]Yes – Attach signed Consent & SPED Referral forms (copy for HS/original to SPED)

CHILD'S MEDICAL INFORMATION

Medical Diagnosis: _____ Any prescribed medication(s): _____
[ ]No Concerns [ ]Diagnosed Asthma [ ]Allergies (Food, Insect, Environmental) [ ]Difficulty seeing [ ]Difficulty hearing
[ ]Seizures [ ]Bleeding Tendencies [ ]Other Medical Concern(s) _____

Medicaid Status: [ ] Ineligible [ ] Eligible [ ] Applied [ ] Former **Medicaid #** _____

Medical Insurance:_____ **Dental Insurance:**_____

Medical Clinic:_____ **Dental Clinic:**_____

OTHER SERVICES CHILD AND/OR FAMILY IS RECEIVING

Was child referred to program by another agency? [ ] No [ ] Yes – Specify :_____
Is your child currently receiving services from: [ ] Karinu [ ]Shriners [ ]Special Needs Clinic [ ]GEIS
[ ]I Famagu'on-ta [ ]Guam Behavioral Health & Wellness Center [ ]Other:_____
Any specific family need or crisis at this time? [ ] No [ ] Yes – Specify :_____
Are you interested in becoming a Parent Volunteer if your child is selected for the Head Start Program? [ ] No [ ] Yes

Application No. _____

MAP TO RESIDENCE

Child's Name: _____Center: _____

Primary Parent: _____Secondary Parent: _____

Primary Contact Numbers: H_____ C_____ W_____

Home Address: _____

House Number **Street Name** **Village**

House Color: _____ Obvious Landmarks (church, bridge, store, etc.): _____

Housing Status : [ ]Own [ ]Live with Relative/Friends [ ]Rent [ ]GHURA Public Housing [ ] Military/Federal Housing

Type of Building: [ ] Full Concrete [ ] Semi-Concrete [ ] Wooden Frame and Tin [ ] Other _____

SCHOOL PLACEMENT: Children will be placed according to school districts with an available Head Start center. If there is no Head Start center in your district, your child will be placed in the closest school district as determined by Head Start. Bussing services are provided to Head Start children as determined by Head Start in consultation with the DPW Division of Bus Operations. Special requests for out-of-district placement may be made by parents and will be approved based on need for the following special circumstances – Special Education placement, foster home, after school care, enrollment of older siblings, and worksite of parents/guardians. If no bussing services are available, parents are responsible for transportation. You may choose to self-transport or use the Guam Mass Transit System.

Are you in need of an OUT OF DISTRICT placement? [ ]No [ ]Yes, Requested Out of District School: _____

Reason: _____

If no space is available at your district school, would you be willing to transport your child to an alternate school? This option will ONLY apply if there is low enrollment at the alternate school and all efforts to recruit within that district have been exhausted.
[ ]No [ ]Yes, Requested Alternate School: _____

ADDITIONAL CONTACT INFORMATION (Please list persons not listed in family application)

Name of Adult	Relationship to Child	Phone Numbers

PUBLIC ASSISTANCE FROM THE PAST 12 MONTHS THAT SUPPORTED THE FAMILY (Check all that apply)

SNAP [ ] Yes [ ] No TANF [ ] Past [ ] Current [ ] Never Medicaid [ ] Yes [ ] Applied [ ]Not Eligible
WIC [ ] Yes [ ] No Child Care Assistance [ ] Yes [ ] No MIP [ ] Yes [ ] No
GHURA [ ] No [ ] Section 8 [ ] Utility Reimbursement [ ] Public Housing [ ]

PARENTS AND GUARDIANS INCOME FROM THE PAST 12 MONTHS THAT SUPPORTED THE FAMILY (Check all that apply)

[ ] Work Income [ ] Rental Income [ ] Gambling/Lottery Winnings [ ] Other: _____
[ ] Retirement [ ] Social Security [ ] Self Employment (May need to provide Statement of Support, Unemployment Verification, or other supporting documents)
[ ] Child Support [ ] Alimony [ ] Unemployment Compensation
[ ] Recycling Income [ ] Food Sales [ ] Flea Market Sales
[ ] Pell Grant/Scholarships /Work Study [ ] Veterans Benefits [ ] Military Family Allotment

PLEASE READ BEFORE SIGNING

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT ALL INCOME IS REPORTED. I UNDERSTAND THAT THIS INFORMATION IS GIVEN TO DETERMINE ELIGIBLITY FOR A FEDERAL PROGRAM AND WILL BE VERIFIED FOR ACCURACY. I UNDERSTAND THAT DELIBERATE MISREPRESENTATION OF THE INFORMATION MAY SUBJECT ME TO PROSECUTION UNDER APPLICABLE LOCAL AND FEDERAL LAWS AND MAY RESULT IN MY CHILD'S INELIGIBILITY FOR HEAD START. THIS PROGRAM DOES NOT DISCRIMINATE BASED ON DISABILITY IN ACCORDANCE WITH THE AMERICANS WITH DISABILITIES ACT.

PARENT SIGNATURE: _____ DATE: _____

REVIEWED BY (STAFF SIGNATURE):_____ DATE: _____