

Documentation needed to be returned with Application

1. Copy of your child's birth certificate
2. Documentation of one month's worth of the most current income for each adult member of the household (paystubs, W-2's, Recent tax return)
3. Public Assistance budget sheet TANF/SNAP award letters (if receiving assistance)
4. SSI documentation (if receiving for any household member)
5. Documentation of Child Support being received (only the child being applied for)
6. If no income we must have documentation of how your household expenses are being paid. This can be a notarized statement from the person(s) assisting you
7. Copy of Custody Court Order if you have one

2024 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
1	\$15,060
2	\$20,440
3	\$25,820
4	\$31,200
5	\$36,580
6	\$41,960
7	\$47,340
8	\$52,720
FOR FAMILIES/HOUSEHOLDS WITH MORE THAN 8 PERSONS, ADD \$5,380 FOR EACH ADDITIONAL PERSON.	

Please be sure to answer all questions, sign, and date the application. If you have any questions please call Holly Green, Head Start Family Advocate, at 585-658-4023, ext. 4125.

Head Start Program of Livingston County

KidStart
5871 Groveland Station Road
Mt Morris, NY 14510
585)658-4023

ENROLLMENT APPLICATION

Child's Name #1 _____ D.O.B. _____ Male _____ Female _____

Race: ___ Indian/Alaskan ___ Asian ___ Black ___ Pacific/Islander ___ White ___ Multi/Bi-Racial ___ Other
Primary Language _____ **Hispanic** ___ Yes ___ No

Child's Name #2 _____ D.O.B. _____ Male _____ Female _____

Race: ___ Indian/Alaskan ___ Asian ___ Black ___ Pacific/Islander ___ White ___ Multi/Bi-Racial ___ Other
Primary Language _____ **Hispanic** ___ Yes ___ No

School District _____ County of Residence _____ Birth Certificate Provided _____

Mailing Address _____

Directions to home _____

Parent/Guardian #1 _____ D.O.B. _____

Relationship to child _____

Address _____

GED/Diploma _____ Highest Level of Education _____

Are you the Primary Adult? _____ yes _____ no

Race _____ Hispanic: ___ yes ___ no

Primary Language _____ Secondary Language _____

Phone Number _____ Email Address _____

Parent/Guardian #2 _____ D.O.B. _____

Relationship to child _____

Address _____

GED/Diploma _____ Highest Level of Education _____

Are you the Primary Adult? _____ yes _____ no

Race _____ Hispanic: ___ yes ___ no

Primary Language _____ Secondary Language _____

Phone Number _____ Email Address _____

Parent/Guardian #3 _____ D.O.B. _____

Relationship to child _____

Address _____

GED/Diploma _____ Highest Level of Education _____

Are you the Primary Adult? _____ yes _____ no

Race _____ Hispanic: ___ yes ___ no

Primary Language _____ Secondary Language _____

Phone Number _____ Email Address _____

Do you have a Custody Court Order? ____ yes ____ no **Documentation on file?** ____ yes ____ no

Is this a Foster Care Placement? ____ yes ____ no

Is a Caseworker working with your family? ____ yes ____ no Name of Caseworker _____
(Foster Care, Preventive, Protective)

Members of Household	D.O.B.	Relationship to Child	Health Concerns

How did you hear about Head Start? _____

Why would you like your child in Head Start? _____

Primary Adult _____ Marital status _____

Community services received by family members:

Does your family receive Food Stamps? (SNAP) ____ yes ____ no

Does your family receive WIC? ____ yes ____ no

Does your family receive HEAP? ____ yes ____ no

Does anyone in your family receive Counseling? ____ yes ____ no

Does everyone in your household have Health Insurance? ____ yes ____ no

Please provide Health Insurance Information for your child below.

Medicaid _____ Policy # for child _____

Child Health Plus _____ Policy # for child _____

Family Health Plus # _____ MVP# _____ FIDELIS# _____

PC Option/BC Option _____ Policy # for child _____

Other _____

Has your child received Early Intervention Services? _____

If yes, what services did they receive?

Does your child have a diagnosed disability or do you have any concerns about your child's growth and/or development such as speech/language, large or small motor skills, or behavior? If yes, please describe

Child's Pediatrician _____

Phone: _____

Any Specialists/Dentist _____

Phone: _____

Do you partner with any other agency or program? _____

Household Income: must provide documentation

		(weekly, hourly, monthly)
Employment _____	Amount _____	per _____
Unemployment _____	Amount _____	per _____
Public Assistance _____	Amount _____	per _____
Child Support for applicant only _____	Amount _____	per _____
SSI/SSDI _____	Amount _____	per _____
Veterans Benefits _____	Amount _____	per _____
Pension _____	Amount _____	per _____
Foster care placement zero income _____		
Other _____	Amount _____	per _____

Number in Family _____ TOTAL INCOME FROM ALL SOURCES _____

INCOME GUIDELINE _____ Family income based on the last 12 months _____

Income Verification used _____

Do you have reliable transportation _____ yes _____ no

I have read this application form. All information given is to the best of my knowledge true, and correct, and will be held in confidence. I understand that this is an application and does not guarantee my child a place in the program.

Parent/Guardian signature _____ Date _____

Staff signature _____ Date _____

Family referred to _____

Contact notes: _____

Reviewed by _____ Date _____



Livingston County Head Start

5871 Groveland Station Road
Mt. Morris, NY 14510

Phone: 585-658-4023
Fax: 585-658-4066

Name of School: Livingston County Head Start

Name of Student: _____ M _____ F _____

Birthdate ____ / ____ / ____ Age _____

This form is intended to address the requirements of the McKinney-Vento Act 42 U.S.C.11435. The questions below are to assist in determining if the student meets the eligibility for criteria provided under the McKinney-Vento Act.

1. Is your current address a temporary living arrangement? _____ Yes _____ No
2. Is this temporary living arrangement due to loss of housing or economic hardship?
_____ Yes _____ No

If you answered YES to the above questions, please complete the remainder of this form. If you answered NO, you may stop here.

Where does the student stay at night?

- _____ in a shelter _____ in a car _____ temporarily with more than one family in a house
- _____ in a motel/hotel _____ moving from place to place
- _____ other (in an arrangement that is not fixed, regular, and adequate and is not described by the other choices)

Name of Parent (s)/ Legal guardian(s) _____) _____

Address _____

Zip _____ Phone _____

Presenting a false record or falsifying records is an offense under Section 37.10, Penal code, and enrollment of a child under false documents subjects the person to liability for tuition and other costs. TEC. Sec.25.002 (3)(d).

Signature of Parent/Legal Guardian _____ Date _____

I certify the above-named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

McKinney-Vento Liaison Signature _____ Date _____