



Grand Forks Head Start
3600 6th Ave N
Grand Forks, ND 58203



Enrollment Checklist

<input type="checkbox"/>	Completed Application (every page filled out)
<input type="checkbox"/>	Signatures on pages:
<input type="checkbox"/>	Documents listed below:

<input type="checkbox"/>	Proof of Age (3 year olds must turn 3 on or before July 31st of that school year)	<input type="checkbox"/> Certified Birth Certificate <input type="checkbox"/> Passport
<input type="checkbox"/>	Proof of Income* (of all parents/guardians in the home for the past 12 months)	<input type="checkbox"/> Individual Income Tax Form 1040 <input type="checkbox"/> W-2 Forms <input type="checkbox"/> Statement from Employer (Letterhead) <input type="checkbox"/> Pay Stub <input type="checkbox"/> Child Support <input type="checkbox"/> TANF <input type="checkbox"/> Work Study, Fellowship, Scholarship, or Grant <input type="checkbox"/> SSI/Social Security <input type="checkbox"/> Unemployment <input type="checkbox"/> Statement of no income if unemployed and have none of the above (available at the main office)
<input type="checkbox"/>	Social Security Number/Card (if applicable)	
<input type="checkbox"/>	Medicaid or Medical Insurance Card (if applicable)	
<input type="checkbox"/>	Immunization Record (within 30 days of child starting school)	

INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED!

Please bring application and all required paperwork to:
3600 6th Ave N., GF ND 58203

➔ If you have questions or need help with the application or documents, please call 701-746-2433 and ask to speak with the enrollment team!!!

Grand Forks Head Start Enrollment Application

Grand Forks Walsh County

Child Information

Legal Name: First _____ Middle _____ Last _____

Date of birth: - -

Age by July 31st 3 4

Gender: Female
 Male

With whom does the child live (for address purposes only)? Mom Dad Both mom and dad

Did you apply last year, but your child did not get in (i.e. were you told your child was on the waiting list the previous year)? YES NO

Race:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Chinese | <input type="checkbox"/> Korean | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Asian (specify): | <input type="checkbox"/> Far East Asian | <input type="checkbox"/> Japanese | <input type="checkbox"/> White |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Filipino | <input type="checkbox"/> Native Hawaiian or Pacific Islander | <input type="checkbox"/> Other Specify _____ |
| <input type="checkbox"/> Biracial/Multi | <input type="checkbox"/> Indian Subcontinent | <input type="checkbox"/> Southeast Asian | |
| <input type="checkbox"/> Black/African American | | | |
| <input type="checkbox"/> Burmese | | | |

Languages spoken at home: Please place a "P" by the Primary language that is spoken in the home and an "S" by the Secondary Language spoken in the home (if any).

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> African Languages | <input type="checkbox"/> East Asian Languages | <input type="checkbox"/> Japanese | <input type="checkbox"/> Native North American/Alaska |
| <input type="checkbox"/> Asian | <input type="checkbox"/> English | <input type="checkbox"/> Middle Eastern Languages | <input type="checkbox"/> Native Languages |
| <input type="checkbox"/> Brazilian | <input type="checkbox"/> European & Slavic Languages | <input type="checkbox"/> Native American Languages | <input type="checkbox"/> Pacific Island Languages |
| <input type="checkbox"/> Caribbean Languages | <input type="checkbox"/> French | <input type="checkbox"/> Native Central/South American & Mexican Languages | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Italian | | <input type="checkbox"/> American Sign Language |

Regardless of language spoken, how well does your child speak English? Very Well Well Not Well Not at all

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1 Name:

Residential address:

City _____ State _____ Zip Code _____

Secondary/Mailing Address:

Home Phone: _____ Cell# _____ E-mail: _____

Place of Employment (Primary Job): _____ Work Phone: _____

Parent/Guardian #2 Name: Same as above

Residential address:

City _____ State _____ Zip Code _____

Secondary/Mailing Address:

Home Phone: _____ Cell# _____ E-mail: _____

Place of Employment (Primary Job): _____ Work Phone: _____

	Parent/Guardian #1:	Parent/Guardian #2:
Name:		
Date of birth:	____/____/____	____/____/____
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Race:		
Is this person the head of household?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Live in home	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Live in home
Marital Status:	<input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Re-Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Re-Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed
Parental Status:	<input type="checkbox"/> Single Parent- Mother Figure Only <input type="checkbox"/> Other relative <input type="checkbox"/> Single Parent- Father Figure Only <input type="checkbox"/> Other family type <input type="checkbox"/> Single Parent-Mother Figure Living with Partner <input type="checkbox"/> Single Parent-Father Figure Living with Partner <input type="checkbox"/> Two Parent family	<input type="checkbox"/> Single Parent- Mother Figure Only <input type="checkbox"/> Other relative <input type="checkbox"/> Single Parent- Father Figure Only <input type="checkbox"/> Other family type <input type="checkbox"/> Single Parent-Mother Figure Living with Partner <input type="checkbox"/> Single Parent-Father Figure Living with Partner <input type="checkbox"/> Two Parent family
What language do you speak?		
How well do you speak English?	<input type="checkbox"/> Very Well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> Not at all	<input type="checkbox"/> Very Well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> Not at all
Highest Grade Completed	<input type="checkbox"/> Adult College Degree/Training Cert <input type="checkbox"/> Adult College or Advance Training <input type="checkbox"/> Adult General Education <input type="checkbox"/> Adult-Grade 10 <input type="checkbox"/> Adult-Grade 11 <input type="checkbox"/> Adult-Grade 12 <input type="checkbox"/> Adult-Grade 9 or less <input type="checkbox"/> Adult High School Grad <input type="checkbox"/> Associate Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree	<input type="checkbox"/> Adult College Degree/Training Cert <input type="checkbox"/> Adult College or Advance Training <input type="checkbox"/> Adult General Education <input type="checkbox"/> Adult-Grade 10 <input type="checkbox"/> Adult-Grade 11 <input type="checkbox"/> Adult-Grade 12 <input type="checkbox"/> Adult-Grade 9 or less <input type="checkbox"/> Adult High School Grad <input type="checkbox"/> Associate Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree
Relationship to enrolling child:	<input type="checkbox"/> Biological Mother <input type="checkbox"/> Biological Father <input type="checkbox"/> Biological Grandfather <input type="checkbox"/> Bio-Grandmother <input type="checkbox"/> Stepmother <input type="checkbox"/> Step Father <input type="checkbox"/> Adoptive Mother <input type="checkbox"/> Adoptive Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> No Biological/Legal relationship <input type="checkbox"/> Other relative:	<input type="checkbox"/> Biological Mother <input type="checkbox"/> Biological Father <input type="checkbox"/> Biological Grandfather <input type="checkbox"/> Bio-Grandmother <input type="checkbox"/> Stepmother <input type="checkbox"/> Step Father <input type="checkbox"/> Adoptive Mother <input type="checkbox"/> Adoptive Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> No Biological/Legal relationship <input type="checkbox"/> Other relative:
In job-training or school?	<input type="checkbox"/> Yes, Full-time <input type="checkbox"/> Yes, Part-time <input type="checkbox"/> No Where? What are you studying?	<input type="checkbox"/> Yes, Full-time <input type="checkbox"/> Yes, Part-time <input type="checkbox"/> No Where? What are you studying?
Please Mark all that Apply:	<input type="checkbox"/> Work Full time <input type="checkbox"/> Work Part time <input type="checkbox"/> Disabled <input type="checkbox"/> Homemaker <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Receiving job training <input type="checkbox"/> Seeking employment	<input type="checkbox"/> Work Full time <input type="checkbox"/> Work Part time <input type="checkbox"/> Disabled <input type="checkbox"/> Homemaker <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Receiving job training <input type="checkbox"/> Seeking employment

OTHER MEMBERS IN HOUSEHOLD

How many people live in your household?		How many are children?		Out of everyone in your household, how many are supported by the listed parent(s) guardian (s) [please include parent(s) in total]	
Name:	Date of Birth:	Gender		How well do they speak English?	Relationship to applying child
1.	/ /	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Very Well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> Not at all	
2.	/ /	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Very Well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> Not at all	
3.	/ /	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Very Well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> Not at all	
4.	/ /	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Very Well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> Not at all	
5.	/ /	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Very Well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> Not at all	
6.	/ /	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Very Well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> Not at all	

FAMILY INFORMATION

(please be as honest as possible, information will remain confidential and will only be used to determine family and child needs/placement priority)

INCOME-BASED RESOURCES

Does Your Family Receive:

TANF Yes No **WIC** Yes No **SNAP** Yes No

Childcare Assistance Yes No **Fuel Assistance** Yes No **Housing Assistance** Yes No

HOUSING INFORMATION/

Where does your family currently live?

Apartment House Community Shelter Is your family homeless

 Friends
 Family
 Hotel/Motel Room
 Community Shelter

} **(Without a home of your own)**

TRANSPORTATION INFORMATION

Own a Vehicle Family or Friend Public Transportation

CHILD MEDICAL INFORMATION

For all questions below→

IF YES, PLEASE SPECIFY/EXPLAIN:

1. Has your child been seen or diagnosed by a specialist for health or developmental concerns?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosis:
2. Does child receive some type of therapy (ex: speech, physical therapy, occupational therapy or psychology)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specialist/Agency:
3. Is your child on an Individual Education Plan (IEP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Proof of Documentation Needed
4. Does your child have a medical provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Received: <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Does your child have a dental provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Doctor:
6. Does your child have health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Dentist:
7. Does your child have Medical Assistance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Insurance Provider #
		Medical Assistance #

OTHER FAMILY/SOCIAL FACTORS

1. Did any person or agency refer you to this program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who or what agency?
2. Has there been documented child abuse or neglect?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Has a parent/guardian been remote/TDY in the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

CHILD CARE INFORMATION

1. Has the child applying been in Head Start before?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When /where?
2. Has the child's sibling been in Head Start before?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When /where?
3. Does the child have a sibling currently in Head Start?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When /where?

TUBERCULOSIS HISTORY

1. Has a family member or contact had tuberculosis disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Has a family member had a positive tuberculin skin test?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Was your child born in a high risk country? (countries other than the U.S., Canada, Australia, New Zealand, or Western European countries?)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Has your child traveled to a high-risk country for more than one week?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

MILITARY FAMILIES

1. Are you or your spouse currently on active duty?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Are both you and your spouse members of the military?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Is there a parent of the applying child currently deployed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3a. Have there been multiple deployments?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Is a parent of the applying child currently in an active combat zone?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

5. Is your family enrolled in the Exceptional Family Member Program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
6. Do any of your immediate family members receive special care:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
6a. For physical conditions requiring one or more visits per year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
6b. For mental health conditions requiring one or more visits per year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
7. Has there been a recent post-deployment (w/in the last 6 months)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
8. Have you been at this base/town less than 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
9. Do you have any family nearby to offer support to your family?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Parent/Guardian #1: How many jobs have you had in the past 12 months? _____

Please fill out for each job

Place of Employment:	Position:	Are you currently employed here?	Work status:	Paid:	Proof of income provided
1.		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Self employed <input type="checkbox"/> Other: _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly	<input type="checkbox"/> YES <input type="checkbox"/> NO
2.		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Self employed <input type="checkbox"/> Other: _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly	<input type="checkbox"/> YES <input type="checkbox"/> NO
3.		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Self employed <input type="checkbox"/> Other: _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly	<input type="checkbox"/> YES <input type="checkbox"/> NO

Parent/Guardian #2: How many jobs have you had in the past 12 months? _____

Please fill out for each job

Place of Employment:	Position:	Are you currently employed here?	Work status:	Paid:	Proof of income provided
1.		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Self employed <input type="checkbox"/> Other: _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly	<input type="checkbox"/> YES <input type="checkbox"/> NO
2.		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Self employed <input type="checkbox"/> Other: _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly	<input type="checkbox"/> YES <input type="checkbox"/> NO
3.		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Self employed <input type="checkbox"/> Other: _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly	<input type="checkbox"/> YES <input type="checkbox"/> NO

Does your family receive:		Proof provided
Child Support/Alimony?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Supplemental Social Security Income (SSI)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Unemployment?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
TANF?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Work Study, Fellowship, Scholarship, or Grant?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other source of income not listed above?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

I certify that the information in this application is accurate and truthful to the best of my knowledge.

SIGN:



Parent/Legal Guardian

Date

Grand Forks Head Start Consent For Child to Be picked Up

Approved Emergency Contacts:

If **neither father nor mother (or legal guardian) can be contacted in an emergency**, Please list at least 2 **people (other than a parent (s) or legal guardian (s))** who live locally and who will be able to pick-up your child from school; they **MUST** be at least 16 years old, if this information changes, you **MUST** provide us with the updated information. **Your child will not be allowed to return to class until you do so.** Please note, your child will not be released to anyone not on this list. No phone authorization will be approved.

Name: <input type="checkbox"/> Emergency <input type="checkbox"/> Release child to	Relationship to Child:
Home Phone:	Cell Phone:
Place of Employment:	Work Phone:
Additional Phone Numbers:	

Name: <input type="checkbox"/> Emergency <input type="checkbox"/> Release child to	Relationship to Child:
Home Phone:	Cell Phone:
Place of Employment:	Work Phone:
Additional Phone Numbers:	

MY CHILD: _____, MAY ALSO BE PICKED UP FROM SCHOOL BY THE FOLLOWING PERSONS:

Name: <input type="checkbox"/> Emergency <input type="checkbox"/> Release child to	Relationship to Child:
Home Phone:	Cell Phone:
Place of Employment:	Work Phone:
Additional Phone Numbers:	

Name: <input type="checkbox"/> Emergency <input type="checkbox"/> Release child to	Relationship to Child:
Home Phone:	Cell Phone:
Place of Employment:	Work Phone:
Additional Phone Numbers:	

Name: <input type="checkbox"/> Emergency <input type="checkbox"/> Release child to	Relationship to Child:
Home Phone:	Cell Phone:
Place of Employment:	Work Phone:
Additional Phone Numbers:	

Name: <input type="checkbox"/> Emergency <input type="checkbox"/> Release child to	Relationship to Child:
Home Phone:	Cell Phone:
Place of Employment:	Work Phone:
Additional Phone Numbers:	

Name: <input type="checkbox"/> Emergency <input type="checkbox"/> Release child to	Relationship to Child:
Home Phone:	Cell Phone:
Place of Employment:	Work Phone:
Additional Phone Numbers:	

