COMMUNITY PROGRESS COUNCIL, INC.
EARLY HEAD START/HEAD START OF YORK COUNTY

EARLY HEAD START
339 E. COTTAGE PLACE, YORK PA 17403
PHONE: 717-846-4600 EXT. 266
FAX: 717-668-8521

HEAD START
226 EAST COLLEGE AVENUE, YORK, PA 17403
PHONE: 717-846-4600 EXT. 266
FAX: 717-848-3054

PREGNANT MOTHER/CHILD APPLICATION FORM

Child's Name: _____ DOB: _____

Social Security Number: _____ Race: _____ Gender: F _____ M _____

Address: _____ APT#_____

City: _____ Zip Code: _____ School District: _____

Primary Language: ❑ English ❑ Spanish ❑Other_____

Parent/Guardian Information

Name: _____ DOB: _____

Address (If different from child): _____

Please provide as many contact phone numbers as possible:

Phone #1	Phone #2	Phone #3	Email

Best time to call: _____

Hours at work/school per week: _____ Consecutive months of employment: _____

Parent/Guardian Information

Name: _____ DOB: _____

Address (If different from child): _____

Please provide as many contact phone numbers as possible:

Phone #1	Phone #2	Phone #3	Email

Best time to call: _____

Hours at work/school per week: _____ Consecutive months of employment: _____

Family Size: Are you pregnant? ❑ YES ❑NO Due Date:_____	Did your child attend another Early Head Start/Head Start Program? ❑ YES ❑NO If Yes, Location:_____	Income Type: ❑ Wages ❑ TANF ❑ Child Support ❑ SSI ❑Unemployment ❑ Retirement ❑ Disability ❑ Other:_____	Custody order in place? ❑ YES ❑NO Is Children, Youth and Families involved? ❑ YES ❑NO
Please bring proof of pregnancy at time of initial intake appointment.	At the time of your initial intake appointment, you will be asked to provide the following information: Proof of Income Birth Certificate Social Security Card Health Insurance Card Physical Form/ Immunization Records		Is child in foster care? ❑ YES ❑NO Do you have educational and medical rights? ❑ YES ❑NO

How did you hear about our program? (circle one)

Family/Friend Flyer Walk-in Community Event Referred by social service agency/doctor Other

Parent Signature: _____ Date: _____

TO BE COMPLETED BY STAFF ONLY

Attempts to contact for enrollment
1st Attempt:_____
2nd Attempt:_____ Processed: Initials _____Date_____/_____/_____
3rd Attempt:_____

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Please Check ALL That Apply		Notes
Do you have any of the following needs or concerns for **your family**?	☐ Domestic Violence ☐ Substance Abuse ☐ Education/ Literacy Difficulties ☐ English as a Second Language Classes ☐ Deceased Parent ☐ Incarcerated Parent ☐ Lack of Family Support System ☐ Training / Employment ☐ Working with Children, Youth and Families ☐ Chronic Medical Condition / Disabilities ☐ Behavioral / Developmental Concerns ☐ Receiving Treatment ☐ Mental Health Concerns ☐ Receiving Treatment ☐ Parenting Education ☐ Legal Services	
Do you have any of the following needs or concerns for your **enrolling child**?	☐ Chronic Medical Condition / Disabilities ☐ Behavioral / Developmental Concerns ☐ Receiving Treatment ☐ Mental Health Concerns ☐ Receiving Treatment	
Are you a…?	☐ Teen Parent (Currently 20 years old or younger) ☐ Legal Guardian / Grandparent of the child ☐ Foster Parent ☐ Joint / Shared Custody ☐ Two Parent Household ☐ Single Parent	
Are you parent / guardian who is…?	☐ Working ☐ Attending School ☐ In Training (EDSI / Work Ready)	
Is there a pregnancy or newborn in the family?	☐ Pregnant ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester ☐ Post-partum Depression ☐ 3 or more children under the age of 5 ☐ 2 children under the age of 5 ☐ Newborn (Currently under 1 year old)	
Is your family experiencing homelessness?	☐ No Shelter ☐ In a Shelter ☐ Multi-family arrangement with documentation ☐ Living with friends / extended family	
Are you having difficulties with any of the following **basic needs**?	☐ Eviction / Foreclosure ☐ Clothing ☐ Food ☐ Utility shut off notices ☐ Health Insurance / Medical Costs	

To be completed by Early Head Start / Head Start Staff

Potential Service Years: 1 2 3 4 5	Referrals: WIC Medical Assistance TANF SNAP Community Center RAP Work Ready ESL LIHEAP
Kindergarten Bound: Yes – 2 No – 0	Previously enrolled in Head Start: Yes No Transitioning from Early Head Start: Yes No

Staff Only
Mini Screening Completed
Date: _____

Initials: _____