Head Start Enrollment
Application 2020-2021

Welcome to Head Start:
Head Start is proud to offer a world-class pre-school program to children and families in Millard, Beaver, Iron, and Washington Counties.

This year we are able to offer two types of classes (types are limited by location):
Part day: 4 days a week (Monday thru Thursday), 4 hours a day, morning or afternoon.
Full day: 5 days a week (Monday thru Friday), 7 hours a day, half day on Friday.
(See other side for locations and types of classes offered)

Children are eligible based on age, income, and child or family need.
• Your child must be at least 3 by September 1.
• If your child turns 5 before September 1, they are required to go to the local school district.

Here is what you need to do to register your child:
• Complete the attached application.
• Return it in person to your nearest Head Start Center (See other side).
• Bring the following items:
  □ Birth Certificate or DCFS School Enrollment Letter for Foster Children
  □ Income Verification (not required for children in foster care)
    (Complete the questionnaire on Page 7 to determine which income documents to include with your application)
  □ Immunization Record – Must have all shots listed below or be on schedule.

<table>
<thead>
<tr>
<th>4 DTaP</th>
<th>3 Polio</th>
<th>3-4 Hib</th>
<th>1MMR</th>
<th>3 HEP B</th>
<th>2 HEP A</th>
<th>1 Varicella or proof of chicken pox</th>
<th>3 PCV 13</th>
</tr>
</thead>
</table>

• Faxed or mailed applications will not be accepted except in special cases.
• If you are unable to return your application in person, or if you are applying during the summer months, please call our toll free number 1-800-796-6070 for instructions.
• See our website for Frequently Asked Questions. www.suu.edu/headstart
# Head Start Centers

<table>
<thead>
<tr>
<th>Head Start Centers</th>
<th>Contact Information</th>
<th>Location Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beaver Head Start</strong> located in</td>
<td>435-438-2281 x5121</td>
<td>Belknap Elementary School 510 N 650 E, Beaver, UT 84713</td>
</tr>
<tr>
<td><strong>Delta Head Start</strong> located in</td>
<td>435-743-6339</td>
<td>Delta, UT 84624</td>
</tr>
<tr>
<td><strong>Fillmore Head Start</strong> located in</td>
<td>435-586-6070</td>
<td>Fillmore Elementary School 555 W 400 S, Fillmore, UT 84631</td>
</tr>
<tr>
<td><strong>Cedar City Head Start Main Center</strong></td>
<td>435-586-6070</td>
<td>2390 W Highway 56 #1, Cedar City, UT 84720</td>
</tr>
<tr>
<td><strong>Cedar City Head Start Gateway Center</strong></td>
<td>435-867-5558</td>
<td>201 E 3800 N, Enoch, UT 84721</td>
</tr>
<tr>
<td><strong>Cedar City Head Start Fiddlers Center</strong></td>
<td>435-233-6695</td>
<td>1830 North Main Street, Cedar City, UT 84721</td>
</tr>
<tr>
<td><strong>Hurricane Valley Head Start</strong></td>
<td>435-635-3442</td>
<td>706 N 195 W, LaVerkin, UT 84745</td>
</tr>
<tr>
<td><strong>Enoch Head Start (North Side of Enoch Elementary)</strong></td>
<td>435-865-6959</td>
<td>4783 Wagonwheel Dr., Enoch, UT 84721</td>
</tr>
<tr>
<td><strong>St. George Head Start Bluff Center</strong></td>
<td>435-674-4545</td>
<td>175 W 900 S #12, St. George, UT 84770</td>
</tr>
<tr>
<td><strong>Parowan Head Start (near the City Pool)</strong></td>
<td>435-477-1715</td>
<td>55 S 300 E, Parowan, UT 84761</td>
</tr>
<tr>
<td><strong>St. George Young Sunset Center</strong></td>
<td>435-359-9321</td>
<td>1469 W. Sunset Blvd, St. George, UT 84790</td>
</tr>
</tbody>
</table>

*These Centers are open during the summer*

**Other Centers are open by appointment please call 1-800-796-6070 to schedule an appointment**
**CHILD DATA**

1. Child’s Name:  
   - First Name  
   - Middle Name  
   - Last Name  

2. Nickname:

3. Date of Birth:  
   - MM  
   - DD  
   - YY

4. Gender:  
   - M  
   - F

5. Family’s Primary Phone:

6. Address:
   - Street  
   - Unit #  
   - City  
   - State  
   - Zip

7. Mailing Address (if different from above):
   - P.O. Box or Street  
   - City  
   - State  
   - Zip

8a. Was the child previously enrolled in Head Start, Early Head Start, Early Intervention, or with the School District Preschool?  
   - YES  
   - NO

8b. If yes, how many years did he/she attend?  
   - 1  
   - 2  
   - 3

8c. Which did he/she attend?  
   - Head Start  
   - Early Head Start  
   - Early Intervention  
   - School District

9. Ethnicity (choose one):
   - Hispanic / Latino  
   - Non-Hispanic / Non-Latino

10. Race:
   - American Indian/Alaska Native  
   - Asian  
   - Black or African American  
   - Bi-racial / Multi-racial  
   - Native Hawaiian/Pacific Islander  
   - White  
   - Unspecified  
   - Other:

11. Language Spoken at Home:
   - Primary:  
     - English  
     - Spanish  
     - Other:
   - Secondary:  
     - English  
     - Spanish  
     - Other:

12. How well does the child speak English?  
   - Very Well  
   - Not Well  
   - Well  
   - Not at all

13a. Do you use or need full-year and/or full-day child care?  
   - YES  
   - NO

13b. Do you receive subsidized child care?  
   - YES  
   - NO

13c. Primary source of child care when child is not in Head Start (choose only one):
   - Family Child Care Home  
   - Child Care Center or Classroom  
   - Public School Pre-Kindergarten Program  
   - At Home  
   - Another Home with a Relative or Unrelated Adult  
   - Other:

14. Family Type (choose only one):
   - Two Parent Family  
   - Single Parent Family (mother figure only)  
   - Single Parent Family (father figure only)  
   - Foster Family  
   - Single Parent Family (mother figure only) Living with Partner  
   - Single Parent Family (father figure only) Living with Partner  
   - Other Relative(s)  
   - Other Family Type:

15. Family Composition
   - Is your family a stepfamily?  
     - YES  
     - NO

16. List all persons who live in the household, including the parents and child applicant.

<table>
<thead>
<tr>
<th>Household Member #1</th>
<th>Age</th>
<th>Relationship to Child</th>
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<tr>
<th>Household Member #2</th>
<th>Age</th>
<th>Relationship to Child</th>
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<tr>
<th>Household Member #3</th>
<th>Age</th>
<th>Relationship to Child</th>
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<tr>
<th>Household Member #4</th>
<th>Age</th>
<th>Relationship to Child</th>
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<tr>
<th>Household Member #5</th>
<th>Age</th>
<th>Relationship to Child</th>
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<tr>
<th>Household Member #6</th>
<th>Age</th>
<th>Relationship to Child</th>
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<tr>
<th>Household Member #7</th>
<th>Age</th>
<th>Relationship to Child</th>
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<tr>
<th>Household Member #8</th>
<th>Age</th>
<th>Relationship to Child</th>
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# PRIMARY PARENTAL FIGURE DEMOGRAPHIC DATA

1. **Name of Primary Parental Figure:**
   - First Name
   - Middle Name
   - Last Name

2. **Email:**
   - Date of Birth: / / 
   - Head of household? Yes No
   - Gender: M F
   - Legal guardian of child applicant? YES NO
   - Home Phone: 
   - Work Phone: 
   - Cell Phone: 

3. **Living & Mailing Address:** (if different from child applicant)
   - Street
   - P.O. Box
   - City
   - State
   - Zip

4. **Language Spoken at Home:**
   - Primary: English Spanish Other:
   - Secondary: English Spanish Other:

5. **How well does this person speak English?**
   - Primary: Very Well Not Well
   - Secondary: Very Well Not Well

6. **Marital Status:**
   - Divorced Married Separated Single Widowed

7. **Occupational Status**
   - Start Date: 
   - **Paying Job:**
     - Full-time
     - Part-time
     - Seasonal
   - **Job Training Program:**
     - With Salary
     - Without Salary
   - **Unemployed:**
     - Time since last job: months
     - No previous employment

8. **Education**
   - School Full-time
   - High School Diploma/GED
   - Trade/Business Qualification
   - Associate Degree
   - Other: ________________

9. **Military Status**
   - Is this parent currently on active duty in the U.S. Military? YES NO
   - Is this parent a veteran of the U.S. military? YES NO

# SECONDARY PARENTAL FIGURE DEMOGRAPHIC DATA

1. **Name of Secondary Parental Figure:**
   - First Name
   - Middle Name
   - Last Name

2. **Email:**
   - Date of Birth: / / 
   - Head of household? Yes No
   - Gender: M F
   - Legal guardian of child applicant? YES NO
   - Home Phone: 
   - Work Phone: 
   - Cell Phone: 

3. **Living & Mailing Address:** (if different from child applicant)
   - Street
   - P.O. Box
   - City
   - State
   - Zip

4. **Language Spoken at Home:**
   - Primary: English Spanish Other:
   - Secondary: English Spanish Other:

5. **How well does this person speak English?**
   - Primary: Very Well Not Well
   - Secondary: Very Well Not Well

6. **Marital Status:**
   - Divorced Married Separated Single Widowed

7. **Occupational Status**
   - Start Date: 
   - **Paying Job:**
     - Full-time
     - Part-time
     - Seasonal
   - **Job Training Program:**
     - With Salary
     - Without Salary
   - **Unemployed:**
     - Time since last job: months
     - No previous employment

8. **Education**
   - School Full-time
   - High School Diploma/GED
   - Trade/Business Qualification
   - Associate Degree
   - Other: ________________

9. **Military Status**
   - Is this parent currently on active duty in the U.S. Military? YES NO
   - Is this parent a veteran of the U.S. military? YES NO
### FAMILY INFORMATION

1. **Type of Housing** (choose only one)
   - [ ] Apartment
   - [ ] House
   - [ ] Community Shelter
   - [ ] Migrant Housing
   - [ ] Homeless / No Housing
   - [ ] Mobile Home / Trailer
   - [ ] Hotel / Motel Room
   - [ ] Other: ________________________________

2. **Housing Payment Arrangement** (choose only one)
   - [ ] Exchange Services for Housing
   - [ ] Own Housing
   - [ ] Make No Payment for Housing
   - [ ] Rent Housing
   - [ ] Receive Subsidized Housing
   - [ ] Other: ________________________________

3. **Length of Time at Current Address:**
   - [ ] Less than 6 months
   - [ ] 6 – 12 months
   - [ ] 1 – 2 years
   - [ ] 2+ years

4. **How many times have you moved in the past 12 months?**
   - [ ] Family Information

5. **Type of Federal or Other Assistance Received** (choose all that apply)
   - [ ] Medicaid or CHIP
   - [ ] (TANF) Temporary Assistance for Needy Families
   - [ ] (SSI) Supplemental Security Income
   - [ ] (WIC) Women, Infants, and Children
   - [ ] (SNAP) Supplemental Nutrition Assistance Program (Food Stamps)
   - [ ] Unemployment

6. **Transportation**
   - [ ] Can you or someone in your family transport your child to Head Start?       YES      NO
   - [ ] If not, how will your child get to Head Start?  ____________________________________________________________

   *(Please note that SUU Head Start does not provide bus transportation.)*

7. **Residency Status** (choose all that apply)
   - [ ] Yes   No   Does the child’s family share housing due to economic struggles? (living with other adults, including relatives)
     - [ ] Yes   No   Is the child living in a shelter, hotel, motel, or lack regular, fixed residence? (domestic violence shelter, transitional housing, etc.)
     - [ ] Yes   No   Is the child living in a car, park, campground, or public place?

8. **Third Party Verification:** If you indicated “yes” to any of the questions under section **Residency Status** above, may SUU Head Start have permission to contact a person or agency who can verify your information?
   - [ ] YES  Legal Guardian Signature: __________________________       NO
   - [ ] Contact Name: ________________________ Phone: _____________________ Affiliation (grandparent, shelter, etc.):

### ADDITIONAL INFORMATION

If any of the following apply, please explain in more detail if desired. Use other side of paper if needed.

1. **Have there been negative changes in employment, living conditions, or income?**
   - [ ]
   - [ ]
   - [ ]

2. **Is anyone living in the household with disabilities and / or health problems?**
   - [ ]
   - [ ]
   - [ ]

3. **Briefly describe the family crisis so we may better prepare for your child (death, divorce, separation, job loss, recent move, substance abuse, incarceration, abuse, mental health, etc.) Use other side of paper if needed**
   - [ ]
   - [ ]
   - [ ]
   - [ ]
   - [ ]
   - [ ]
   - [ ]
   - [ ]
   - [ ]
   - [ ]
   - [ ]
   - [ ]
   - [ ]
   - [ ]
   - [ ]
   - [ ]
   - [ ]
   - [ ]
CHILD’S HEALTH QUESTIONARE

In order to provide the best services for your child and his/her needs, please answer the following:

**Social Emotional**

- Does your child interact with other children when in a group setting? [ ] Yes  [ ] No
- Does he or she often get overstimulated? [ ] Yes  [ ] No
- Does he or she often hit, kick or bite? [ ] Yes  [ ] No
- Can he or she make eye contact with me while we talk? [ ] Yes  [ ] No

**Language/Communication**

- Do people outside of your family understand what he/she says? [ ] Yes  [ ] No
- Can he/she say their own name? [ ] Yes  [ ] No
- Can he/she speak in 3-5 word sentences or more? [ ] Yes  [ ] No

**Cognitive**

- Can your child understand one step directions? [ ] Yes  [ ] No
- Can your child do imaginary play (like a banana is a phone)? [ ] Yes  [ ] No
- Can your child stay with an activity for 5 min. or more? [ ] Yes  [ ] No

**Movement**

- Can your child hop on one foot? [ ] Yes  [ ] No
- Can your child feed him or herself with a spoon? [ ] Yes  [ ] No
- Can your child go from sitting to standing on their own? [ ] Yes  [ ] No
- Is your child able to consistently use the toilet by him/herself? [ ] Yes  [ ] No
- Is your child able to change their own clothes if they have a wetting accident? [ ] Yes  [ ] No

**Education**

- Has your child ever been in a classroom setting before? [ ] Yes  [ ] No
- Has your child attended a School District Preschool? [ ] Yes  [ ] No
- Does your child have an IEP? **If yes, please provide a copy** [ ] Yes  [ ] No

Did your child have health problems at birth? If so, please describe:

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Do you have concerns about your child’s overall health and development?

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

If you answered yes to any of the above questions, please explain:

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
Head Start Performance Standards require that all children be up to date or on schedule with all immunizations and well child care health and dental exams.

1. If you do not currently have a doctor, dentist, or a way to pay for appointments would you like help? ☐ YES ☐ NO

2. Conditions your child has which may be important in an emergency (choose all that apply):

<table>
<thead>
<tr>
<th>Allergies</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insect Bites:</td>
<td>__________________________</td>
</tr>
<tr>
<td>Food:</td>
<td>__________________________</td>
</tr>
<tr>
<td>Medication:</td>
<td>__________________________</td>
</tr>
<tr>
<td>Other:</td>
<td>__________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Conditions</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Seizure</td>
<td></td>
</tr>
</tbody>
</table>

3. Is the condition(s) currently under control / care by physician? ☐ YES ☐ NO

4. Are there any concerns expressed by (choose one):

| Medical Provider | ☐ |
| Program Staff | ☐ |
| Primary Care Provider | ☐ |
| Social Service Agency | ☐ |
| Family Member | ☐ |
| Other: | __________________________ |

5. Medical Insurance Providers:

| Medicare / Medicaid | ☐ |
| Private | ☐ |
| Child Health Insurance Program (CHIP) | ☐ |
| No Coverage | ☐ |
| Other: | __________________________ |

6. Insurance Effective Date: ________________ (MM/DD/YY)

<table>
<thead>
<tr>
<th>Primary Insurance</th>
<th>☐ Yes ☐ No ☐ N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Coverage Included</td>
<td>☐ Yes ☐ No ☐ N/A</td>
</tr>
</tbody>
</table>

7. Current Medical Provider/Clinic: 

   | Phone #: | Date of Last Exam: (MM/DD/YY) |

8. Current Dental Provider: 

   | Phone #: | Date of Last Dental Exam: (MM/DD/YY) |

9. Do you have any concerns about your child’s overall health? 

____________________________________________________________________________________________________
____________________________________________________________________________________________________
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____________________________________________________________________________________________________
EMERGENCY CONTACT INFORMATION

1. Child’s Name:
   First Name ___________________________________________ Last Name ________________________________
   Date of Birth: (MM/DD/YY)

2. Medical Emergency Consent:
   In case of injury or medical emergency, my signature below authorizes Head Start staff to give permission to any doctor, nurse, hospital personnel, or paramedic to provide medical care as they (medical personnel) deem necessary in the best interest of my child.

X ___________________________ X ___________________________
Signature of Parent / Legal Guardian Date Signature of Parent / Legal Guardian Date

3. Primary Parent’s Emergency Phone Numbers:
   Phone 1: _____________________________________________
   □ Home □ Work □ Cell □ Other: _____________________________
   Phone 2: _____________________________________________
   □ Home □ Work □ Cell □ Other: _____________________________

4. Secondary Parent’s Emergency Phone Numbers:
   Phone 1: _____________________________________________
   □ Home □ Work □ Cell □ Other: _____________________________
   Phone 2: _____________________________________________
   □ Home □ Work □ Cell □ Other: _____________________________

5. Emergency Contacts:
   If parent/guardian cannot be reached, who will know where to find you or be responsible for your child?

   Emergency Contact 1:
   Name: _____________________________________________
   Address: Street ________________________________________ City ________________________________
   Gender: M F
   Phone 1: ___________________________ Phone 2: ___________________________
   Relationship to Child: ___________________________

   Emergency Contact 2:
   Name: _____________________________________________
   Address: Street ________________________________________ City ________________________________
   Gender: M F
   Phone 1: ___________________________ Phone 2: ___________________________
   Relationship to Child: ___________________________

   Emergency Contact 3:
   Name: _____________________________________________
   Address: Street ________________________________________ City ________________________________
   Gender: M F
   Phone 1: ___________________________ Phone 2: ___________________________
   Relationship to Child: ___________________________

   Emergency Contact 4:
   Name: _____________________________________________
   Address: Street ________________________________________ City ________________________________
   Gender: M F
   Phone 1: ___________________________ Phone 2: ___________________________
   Relationship to Child: ___________________________

   Emergency Contact 5:
   Name: _____________________________________________
   Address: Street ________________________________________ City ________________________________
   Gender: M F
   Phone 1: ___________________________ Phone 2: ___________________________
   Relationship to Child: ___________________________

In the event of a medical or community emergency, SUU Head Start staff will transport your child if you or no one from your contact information can be located.

Transportation Release: I hereby authorize the persons listed above to pick up my child.

X ___________________________ X ___________________________
Signature of Parent / Legal Guardian Date Signature of Parent / Legal Guardian Date
Primary Parental Figure:
Name: ______________________________________

1. Did this parent start working with his/her current employer on or before January 2019?
   - YES  Turn in your 2019 W2.
   - NO, he/she started after January 2020.
     Turn in all your paystubs AND an Employment Verification Form, DWS 630, or a letter from your employer stating your monthly income. An Employment Verification Form is attached to this application.

2. Does this parent collect unemployment insurance?
   - YES  Turn in unemployment insurance statement or letter
   - NO

3. Does this parent collect child support, even for a child who is not being enrolled for Head Start?
   - YES  Turn in an ORS statement or a divorce decree. If this is an informal arrangement, turn in a letter from the provider that states how much he/she provides.
   - NO

4. Does this parent receive any grants or scholarships?
   - YES  Turn in documentation of grants and scholarships you have been awarded.
   - NO

5. Does this parent receive Supplemental Security Income (SSI) benefits, including on behalf of children? Not to be confused with SSDI.
   - YES  Turn in a statement that specifically states SSI.
   - NO

6. Does this parent receive Family Employment Program (FEP) benefits from Workforce Services?
   - YES  Turn in a statement of FEP.
   - NO

7. Does this parent receive Social Security benefits other than SSI, including on behalf of children?
   - YES  Turn in your Benefit Verification Letters available through www.ssa.gov.
   - NO

8. Does this parent receive assistance from family, friends, or organizations (church, etc.) in the form of cash, assistance with payments (they pay your rent, phone bill, buy/provide groceries, etc.), or housing (you live with them free of charge)?
   - YES  Provide a letter written by the individual or organization assisting you that describes what type of assistance they provide to you.
   - NO

Secondary Parental Figure:
Name: ______________________________________

1. Did this parent start working with his/her current employer on or before January 2019?
   - YES  Turn in your 2019 W2.
   - N/A
   - NO, he/she started after January 2020.
     Turn in all your paystubs AND an Employment Verification Form, DWS 630, or a letter from your employer stating your monthly income. An Employment Verification Form is attached to this application.

2. Does this parent collect unemployment insurance?
   - YES  Turn in unemployment insurance statement or letter
   - NO

3. Does this parent collect child support, even for a child who is not being enrolled for Head Start?
   - YES  Turn in an ORS statement or a divorce decree. If this is an informal arrangement, turn in a letter from the provider that states how much he/she provides.
   - NO

4. Does this parent receive any grants or scholarships?
   - YES  Turn in documentation of grants and scholarships you have been awarded.
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   - NO

8. Does this parent receive assistance from family, friends, or organizations (church, etc.) in the form of cash, assistance with payments (they pay your rent, phone bill, buy/provide groceries, etc.), or housing (you live with them free of charge)?
   - YES  Provide a letter written by the individual or organization assisting you that describes what type of assistance they provide to you.
   - NO

Legal Guardian Signature(s)
I certify that the information in this application is correct to the best of my knowledge and is subject to verification.

X ____________________________ Date ____________________________
Legal Guardian

X ____________________________ Date ____________________________
Legal Guardian
Required Documents
- Birth Certificate or DCFS School Enrollment Letter (for foster children)
- Immunization Record – Make sure to copy the entire card, and make sure the name is on the copy.
- Income Verification – Refer to page 7 of the application.

Schedule: Would you like the full day option (7 hours 4 days 1/2 days on Friday) if available?  Yes  No

Iron County: Cedar Main  Fiddlers  Gateway  Enoch  Parowan
- AM Class
- PM Class
- Full Day

Washington County: St. George Main
- AM Class
- PM Class
- Full Day Class

Millard County: Delta
- AM Class
- Full Day Class

Application Received by: ____________________________  Date: ___________________

Interview Format:  □ In Person  □ Telephone

Application Review Conducted by: ____________________________________________ Date: ___________________

Eligibility Determination Statement  I hereby do certify that the family is eligible to participate in the H.S. Program. I attest that I have examined the documents checked above and certify that the family is eligible in accordance with Head Start regulations and ERSEA policies.

Staff Signature: ____________________________ Date: ___________________  FCE Manager Verification:

Staff Name: ____________________________ Title: ____________________________