FORM 2-Head Start Application

Stockbridge-Munsee Community
ELECTA QUINNEY
Head Start
W13429 Cherry Street • Bowler, WI 54416
Phone: 715-793-4993 Fax: 715-793-4994

Little Ones Leave Lasting Impressions

APPLICATION AND ELIGIBILITY VERIFICATION* for the SCHOOL YEAR _____

*APPLICATION NO LONGER REQUIRES FINANCIAL INFORMATION

APPLICANT INFORMATION

Child's First Name	Last Name	Date of Birth
Physical Street Address		City, State, Zip
Mailing Address (If Different from Physical Address) ☐-Same		City, State, Zip
Home Phone	Cell Phone	Message Phone

FAMILY SUPPORTS

Please Indicate which Program(s) Your Family Participates in

☐ - Social Security/SSI	☐ - Veteran's Admin	☐ - Fed/State Tax Documents
☐ - SNAP/Food Share	☐ - Medicare/Medicaid	☐ - Economic Support
☐ - WI Works	☐ - Other	

HEAD START SERVICES

Please Check All Services Applying For

☐ - Expectant Mother ☐ - Head Start (3-Yr Old) ☐ - Head Start (4-Yr Old)

Names of Child/Children Enrolling in Head Start

Name	DOB	3-Year Old / 4-Year Old

PERSONAL DATA-TRIBAL AFFILIATION

Tribal Affiliation _____ **OR** Parent/Grandparent Tribal Affiliation & Enrollment # _____

Enrollment # _____

☐	Stockbridge-Munsee Enrolled	☐	Other
☐	Direct Descendant	☐	Non-Native
☐	2nd Line Descendant		
☐	3rd Line Descendant		

Citizenship

U.S. Citizen	☐ - Yes ☐ - No
Gender	☐ - Yes ☐ - No
Copy of Birth Certificate (Attached)	☐ - Yes ☐ - No
Copy of Child's Medical Insurance	☐ - Yes ☐ - No

Transportation

Morning	☐ - Bus ☐ - Parent Drop Off
Afternoon	☐ - Bus ☐ - Parent Drop Off

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Family Status/At-Risk Criteria *Please Check All that Apply*

☐	Teen Parent	☐	Single Parent
☐	Indian Child Welfare	☐	Disabled Parent
☐	Grandparent(s) Raising Grandchild	☐	Foster/Kinship Care
☐	Substance Abuse	☐	Relative/Guardian Raising Child
☐	Incarcerated Parent	☐	Child Behavior Concerns
☐	Domestic Violence	☐	Unemployed
☐	Recent Death of Immediate Family Member	☐	Mental Health (Parent/Guardian or Child)
☐	Other Special Circumstances (Please Explain)		

Special Services *If your Child has been Referred for Special Services Please Check All that Apply*

☐	Speech/Language	Please Explain
☐	Physical Disability	Please Explain
☐	Cognitive Delay	Please Explain

Parent Education / Background / Employment

Please list High School or equivalent and all colleges/ universities attended or places of work

Name and (Location of School-City)	Program/Job Title	Dates Attended	Degree earned, if applicable
Name and (Location of School-City)	Program/Job Title	Dates Attended	Degree earned, if applicable
Name and (Location of School-City)	Program/Job Title	Dates Attended	Degree earned, if applicable
Name and (Location of School-City)	Program/Job Title	Dates Attended	Degree earned, if applicable

Family Household

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Number of People Living in Household _____ Number of Dependents Living in Household _____

Please list ALL PERSONS living in the household.

Name	Relationship to Child	DOB

Certification

I hereby apply for Head Start services from the Stockbridge-Munsee Community. I certify that the language in this application is true and correct. I authorize Head Start to process my application and verify the information contained in it. I further release other parties, including schools and governmental programs, to provide requested information to the Stockbridge-Munsee Electra Quinney Head Start so it may process my application. I understand that the falsification or material omission of information on this application shall be grounds for the denial of services and may result in legal action against me. I agree to abide by the program requirements outlined in the Head Start performance standards in relation to services provided based on this application and understand that I may have appeal rights under the Head Start Policy Council.

Parent Signature	Date	Verifying Head Start Staff	Date