



2096 Red Arrow Trail  
Madison, WI 53711

Tel: (608) 275-6740

Fax: (608) 275-6756

www.reachdane.org

## Application for Enrollment

### Head Start Early Head Start Child Care

Dear Parent/Guardian:

Thank you for your interest in Reach Dane! Reach Dane is a federally funded agency that provides Head Start and Early Head Start services for low income families in Dane and Green counties. Reach Dane provides high-quality early childhood services to children ages 0-5 through center-based and home-based programs.

Proof of income is required to determine eligibility for Head Start and Early Head Start and is a part of the application process. Please complete the attached application and submit it and proof of income to:

Reach Dane  
2096 Red Arrow Trail  
Madison, WI 53711  
Attn: Enrollment

You can also fax the application and proof of income to (608) 275-6756 Attn: Enrollment

#### Examples of Acceptable Income Forms:

- A copy of your 2018 Federal Tax return
- 2018 W-2 Tax Statements from all employers
- Paycheck stub from current employer  
(if you have been at your job for more than 1 year)
- SSI Documentation
- Unemployment Payment
- Child Support
- W-2 (Wisconsin Works) Paperwork
- Foster Care/Kinship Care Placement for the Enrolling Child

Please call us at (608) 275-6740 if you have any questions or concerns!

Please note that applications are processed throughout the program year. Please contact us with any changes in address and/or phone number so we are able to contact you. Thank you for your interest in Head Start/Early Head Start!

Sincerely,

Reach Dane Enrollment Staff

*"Reach Dane changes the lives of underserved children and families through educational and supportive services"*



2096 Red Arrow Trail  
Madison, WI 53711

## APPLICATION FOR ENROLLMENT

### Head Start, Early Head Start, & Child Care

Phone: 608-275-6740

Fax: 608-275-6756

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Acceptance to Head Start and Early Head Start is based on the income and needs of the child/family and **NOT** first-come first-served

**Primary Applicant:** *please circle* **Pregnant Mother** **Child**

#### CHILD INFORMATION:

**Child's Legal Name** (Last): \_\_\_\_\_ (First): \_\_\_\_\_ (Middle): \_\_\_\_\_

**Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Gender:** Male Female **Social Security #:** \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_  
mo. day year

**Race of Child:** *Circle All* American Indian or Alaska Native Asian Black/African American  
*That Apply* Native Hawaiian/Pacific Islander White Bi-Racial/Multi Racial Other (specify): \_\_\_\_\_

**Ethnicity:** Hispanic/Latino Non-Hispanic/Latino

**Child's Primary Language:** English Spanish Hmong Other (Specify): \_\_\_\_\_

**Speaks English:** Proficient Moderate Little None

**Does your child receive Medical Assistance?** Yes No MA/Forward ID Number: \_\_\_\_\_

**Does your child have private insurance?** Yes No Company: \_\_\_\_\_

**Is this child currently in Early Head Start?** Yes No **If yes, who is your Family Advocate?** \_\_\_\_\_

**Living Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Mailing Address** (if different than living address): \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Child Lives With:**  Both Parents  Mother  Father  Foster Care  Guardian  Other *specify:* \_\_\_\_\_

**Primary Parent/Guardian Name:** (Last): \_\_\_\_\_ (First): \_\_\_\_\_ **Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Relationship to Child** *please circle* : Mother Father Stepparent Foster Parent Guardian Other *specify:* \_\_\_\_\_

**Address** (if different than child's): \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Phone Number:** Home: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_

**How do you prefer we contact you?** *circle all that apply* Phone Call Text Email

**Social Security #:** \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Currently Pregnant?** Yes No N/A **If yes, due date:** \_\_\_\_\_ **Do you have medical coverage/health insurance?** Yes No

**Race:** *Circle All* American Indian or Alaska Native Asian Black/African American Native Hawaiian/Pacific Islander White  
*That Apply* Bi-Racial/Multi Racial Other (specify): \_\_\_\_\_ **Ethnicity:** Hispanic/Latino Non-Hispanic/Latino

**Primary Language:** English Spanish Hmong Other (Specify): \_\_\_\_\_

**Speaks English:** Proficient Moderate Little None **Currently in the Military or Military Veteran?** Y N

**Highest Grade Completed:** *please circle* Grade 9 or less 10 11 12 High School Graduate GED HSED Some College Associates Bachelor Master

**Secondary Parent/Guardian Name:** (Last): \_\_\_\_\_ (First): \_\_\_\_\_ **Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Relationship to Child** *please circle*: Mother Father Stepparent Foster Parent Guardian Other *specify:* \_\_\_\_\_

**Address** (if different than child's): \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Phone Number:** Home ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_

**How do you prefer we contact you?** *circle all that apply* Phone Call Text Email

**Social Security #:** \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Currently Pregnant?** Yes No N/A **If yes, due date:** \_\_\_\_\_ **Do you have medical coverage/health insurance?** Yes No

**Race:** *Circle All* American Indian or Alaska Native Asian Black/African American Native Hawaiian/Pacific Islander White  
*That Apply* Bi-Racial/Multi Racial Other (specify): \_\_\_\_\_ **Ethnicity:** Hispanic/Latino Non-Hispanic/Latino

**Primary Language:** English Spanish Hmong Other (Specify): \_\_\_\_\_

**Speaks English:** Proficient Moderate Little None **Currently in the Military or Military Veteran?** Y N

**Highest Grade Completed:** *please circle* Grade 9 or less 10 11 12 High School Graduate GED HSED Some College Associates Bachelor Master

**Marital Status of Parent(s)** *(please circle:)*

Married Divorced Separated Widowed

Never Married: Living Together

Never Married: Not Living Together

**Current Living Situation** *(please circle:)*

Rent Own

Or Living with:

Family Friends Shelter

Other Homelessness *(describe):* \_\_\_\_\_**Total # of OTHER people living in your household. INCLUDE ALL SIBLINGS:** \_\_\_\_\_ *attach paper if more space is needed*

1. Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F

Relationship to applicant: \_\_\_\_\_ Any Income? Y / N *(if yes, please specify)* \_\_\_\_\_

2. Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F

Relationship to applicant: \_\_\_\_\_ Any Income? Y / N *(if yes, please specify)* \_\_\_\_\_

3. Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F

Relationship to applicant: \_\_\_\_\_ Any Income? Y / N *(if yes, please specify)* \_\_\_\_\_

4. Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F

Relationship to applicant: \_\_\_\_\_ Any Income? Y / N *(if yes, please specify)* \_\_\_\_\_**Birth History:**Is this your first pregnancy? *(please circle)* Yes No

Have you/did you receive regular prenatal care during this pregnancy? Yes No

Which month was your first prenatal visit? *(please circle)* 1 2 3 4 5 6 7 8 9

Is/Was your pregnancy determined to be High Risk by a doctor or health care provider? Yes No

Are you currently seeing a Public Health Nurse or PNCC? Yes No

Is the applicant child in childcare now? *(please circle)* Yes No What hours is child in care? \_\_\_\_\_Do you have child care subsidy from *(please Circle):* County City How much is your weekly co-pay? \_\_\_\_\_Type of care *(please circle)?* Center Family Day Care Friend Family Member

Address/Location? \_\_\_\_\_

Are you interested in full-day child care with us? *(please circle)?* Yes No Days and hours you need care: \_\_\_\_\_Does the applicant child have a diagnosed disability? Yes No

Describe the diagnosed disability: \_\_\_\_\_

Does your child have Individualized Education Plan or Individualized Family Support Plan? IEP IFSP

Is an IEP or IFSP underway for this child? Yes No

Does your child receive any special services from a public school or Birth-3 agency? Yes No

Name of Public School: \_\_\_\_\_

If yes, which of the following special services?

Speech/Language Early Childhood Education Physical Therapy Occupational Therapy

Does your child have a suspected disability? Yes No

Describe the suspected disability: \_\_\_\_\_

Does anyone else in your family have a diagnosed or suspected disability? Yes No

Who? (Describe): \_\_\_\_\_

# IMPORTANT!

Detailed answers to these questions help us determine placement.

Each answer is evaluated and contributes to the overall need of the child and family.

(If you need more writing space, you may attach a separate piece of paper with your answers and child's name & date of birth written at the top)

1. How did you hear about Us? *please circle* Birth to 3 School Human Services Doctor/Nurse WIC Flyer  
Newspaper Ad Internet Search Friend or Family Member Other: *please explain* \_\_\_\_\_

2. What program are you interested in for this child? *please circle all that you are interested in*

Home-Based Early Head Start (Pregnant Mother, 0-3 years)

Home-Based Head Start (3-5 years)

Center-Based Early Head Start (6 weeks-3 years) \*child care subsidy required

Part-Day Head Start (3-5 years)

Infant/Toddler Child Care (6 weeks-3 years) \*private pay or child care subsidy

Extended-Day (3-5 years) \*limited transportation

Full-Day Head Start (3-5 years) \*child care subsidy required, no transportation provided

**For Head Start:** Address for Bus Pick-Up: \_\_\_\_\_ Address for Bus Drop-Off: \_\_\_\_\_

Are you able to provide transportation for your child? Y N *Note: transportation is limited by service area*

3. Are you currently experiencing or did you experience any health problems or complications during this pregnancy, delivery, or after birth?

4. How long did the child stay in the hospital at birth?

5. Were there any problems or concerns at your child's birth or in his/her early development? (Please specify)

6. What are your current concerns about your child? (Health, development, speech, taking medication, etc. Please Specify)

7. How would you describe your child's behavior? Any concerns? (Please specify)

8. Have any major things happened to affect your child? (Homelessness, family violence, foster care, neglect, incarceration, death of family member, etc., please describe)

9. Do you have any concerns about providing for your family's basic needs? (Clothing, housing, food, financial, employment, etc., please specify)

10. Does anyone in your immediate family have health, dental, nutrition, or mental health concerns? (Please specify)

11. Are there any other concerns you have for any family members? (Parenting skills, drug or alcohol issues, please specify)

12. What are your current child care needs? (child care to meet work schedule not available and/or not affordable, please explain)

13. Do you receive any of the following services? *Circle all that apply* Subsidized Housing FoodShare WIC

