Department of Education
Guam Head Start Program
APPLICATION (Part One)

FOR OFFICAL USE ONLY Center: ____Application Number: ________________________

CHILD INFORMATION – Child's name MUST reflect birth certificate for documentation purposes.				
Child's Legal Name (Last)	**(First and Middle Initial)**	**Date of Birth**	**Sex**	**Social Security #**

Mailing Address:

City State Zip Code

Citizenship: [ ]U.S. Citizen [ ]FSM Citizen [ ]Belau Citizen [ ] Resident Alien [ ]Non-Resident

RACE (check ALL that apply): [ ]American Indian/Alaskan [ ]Asian [ ]African American [ ]Caucasian [ ]Hispanic [ ]Pacific Islander [ ]Other(s) – Specify:______________________________________

Child's PRIMARY Language: **Family's PRIMARY Language:**

CHILD'S MEDICAL INFORMATION

Medical Diagnosis: ______________________________ Any prescribed medication(s): _____________________________________

Medical Insurance:____________________________________ Dental Insurance:____
Medicaid Status: [ ] Ineligible [ ] Eligible [ ] Applied [ ] Former MIP Status: [ ] Yes [ ] No

Medical Clinic:_______________________________________ Dental Clinic:____

HOUSEHOLD PARENT/GUARDIAN INFORMATION

First and Last Name	DOB	Ethnicity (ex. Chamorro, Filipino, etc.)	Highest Grade Completed	Diploma/GED /NA	Occupation	Full/Part Time
[ ]Mother [ ]Guardian [ ]Foster [ ]POA [ ]Not in Household						
Contact Information H /C /W /e-mail _________________________________						

First and Last Name	DOB	Ethnicity (ex. Chamorro, Filipino, etc.)	Highest Grade Completed	Diploma/ GED /NA	Occupation	Full/Part Time
[ ]Father [ ]Guardian [ ]Foster [ ]POA [ ]Not in Household [ ]In Birth Certificate						
Contact Information H /C /W /e-mail _________________________________						

Number in Family: ________ **Marital Status**: [ ]Single [ ]Married [ ]Divorced [ ]Separated [ ]Widowed [ ]Common-Law
Family's Primary Contact Person for Head Start (MUST be listed above): ____
Are you a former Head Start parent? [ ] Yes [ ] No Are you interested in being a parent volunteer? [ ] Yes [ ] No

OTHER MEMBERS IN HOUSEHOLD SUPPORTED BY THE PARENTS AND GUARDIANS

First and Last Name	DOB	Relation to child: brother, sister, etc.	First and Last Name	DOB	Relation to child: brother, sister, etc.

ADDITIONAL CONTACT INFORMATION (Please list persons not listed in family application)

Name of Adult	Relationship to Child	Phone Numbers

FAMILY INFORMATION (Check all that apply)

SNAP [ ] Yes [ ] No TANF [ ] Past [ ] Current [ ] Never WIC [ ] Yes [ ] No U.S. Veteran [ ] Yes [ ] No

PARENTS AND GUARDIANS INCOME FROM THE PAST 12 MONTHS THAT SUPPORTED THE FAMILY (Check all that apply)

[ ] Work Income [ ] Rental Income [ ] Gambling/Lottery Winnings [ ] Other: ___________________________
[ ] Retirement [ ] Social Security [ ] Self Employment (May need to provide Statement of Support,
[ ] Child Support [ ] Alimony [ ] Unemployment Compensation Unemployment Verification, or other supporting
[ ] Recycling Income [ ] Food Sales [ ] Flea Market Sales documents)
[ ] Pell Grant/Scholarships /Work Study [ ] Veterans Benefits [ ] Military Family Allotment
[ ]Child Care Assistance [ ] GHURA Section 8 [ ] GHURA Utility Reimbursement [ ] GHURA Public Housing

FOR OFFICAL USE ONLY Center: ____Application Number: ________________________

MAP TO RESIDENCE

Child's Name: ____

Primary Parent: ___________________________________**Secondary Parent:** ___________________________________

Primary Contact Numbers: H_________________________ C_________________________ W_________________________

Home Address: ____

House Number   Street Name   Village

House Color: ___________________ Obvious Landmarks (church, bridge, store, etc.): ___________________________________

Housing Status : [ ]Own [ ]Live with Relative/Friends [ ]Rent [ ]GHURA Public Housing [ ] Military/Federal Housing

Type of Building: [ ] Full Concrete [ ] Semi-Concrete [ ] Wooden Frame and Tin [ ] Other ________________________________

CENTER HOURS OF OPERATION / BUSSING SERVICES:

- Morning session of from 8:30am to 12:30pm. Bussing services are provided to and from designated bus stops within the district.
- Afternoon session is from 12:30pm to 4:30pm. Some afternoon sessions have bussing to school. Parents are responsible for transportation after school.
- Full Day session is from 8:30 am to 2:43pm. Bussing services are provided in the morning from designated bus stops within the district. Parents are responsible for transportation after school.

SCHOOL PLACEMENT: Children will be placed according to school districts with an available Head Start center as determined by Head Start. Special requests for out-of-district placement will be considered based on any of the following: Special Education placement, needs of foster parents, after school care for parents who are working or going to school,

If there is no bussing for my district, I am able to provide transportation as needed. [ ] YES [ ]NO

Are you in need of an OUT OF DISTRICT placement? [ ]No [ ]Yes, Requested Out of District School: ______________________

Reason: ____

If no space is available at your district school, would you be willing to transport your child to an alternate school? This option will ONLY apply if there is low enrollment at the alternate school and all efforts to recruit within that district have been exhausted. [ ]No [ ]Yes, Requested Alternate School: ______________________________________

CHILD'S SPECIAL NEEDS INFORMATION

Disability Status: [ ]None [ ] **Diagnosed** – Attach signed consent and related document (Current IEP)

Do you have concerns about your child's development that have not been evaluated? Check all that apply:

[ ] None [ ]Vision [ ]Developmental [ ]Hearing [ ]Speech [ ] Behavior [ ]Other___________________________________

Attach signed Consent form, Universal Referral form, and completed ASQ and/or ASQ:SE

Has your child ever received services from the following: [ ]Never [ ] Past [ ] Present

[ ] Karinu [ ]Shriners [ ]Special Needs Clinic [ ]GEIS [ ] Isa Psychology [ ]Guam Behavioral Health & Wellness Center

[ ]Other:____

Any specific family need or crisis at this time? [ ] No [ ] Yes – Specify ____

PLEASE READ BEFORE SIGNING

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT ALL INCOME IS REPORTED. I UNDERSTAND THAT THIS INFORMATION IS GIVEN TO DETERMINE ELIGIBLITY FOR A FEDERAL PROGRAM AND WILL BE VERIFIED FOR ACCURACY. I UNDERSTAND THAT DELIBERATE MISREPRESENTATION OF THE INFORMATION MAY SUBJECT ME TO PROSECUTION UNDER APPLICABLE LOCAL AND FEDERAL LAWS AND MAY RESULT IN MY CHILD'S INELIGIBILITY FOR HEAD START. THIS PROGRAM DOES NOT DISCRIMINATE BASED ON DISABILITY IN ACCORDANCE WITH THE AMERICANS WITH DISABILITIES ACT.

PARENT SIGNATURE: ____ **DATE:** ____________________________

REVIEWED BY (STAFF SIGNATURE):____ **DATE:** ____________________________