

**La Clínica de Familia
Early Head Start Application**

_____ **Center Based Program**

_____ **Home Based Program**

(Please print and use a pen) Answer all questions. Incomplete applications will not be considered for enrollment.

1. Child's Legal Name: Last: _____ First: _____ Sex: M/ F	
Date of Birth: _____ Age: _____	Is your child a U.S. Citizen/ Legal Resident? Yes / No
Child's primary language: English / Spanish / Other _____	Child's ethnicity: Anglo / Black / Hispanic / American Indian / Other _____
Parent's primary language: English / Spanish / Other _____	Parent's ethnicity: Anglo / Black / Hispanic / American Indian / Other _____
2. Parent/ Guardian Name(s):	
Mother: _____ DOB: _____	Spouse: _____ DOB: _____
Street Address: _____ City: _____	Street Address: _____ City: _____
State: _____ Zip Code: _____	State: _____ Zip Code: _____
Mailing Address: _____ City: _____	Mailing Address: _____ City: _____
State: _____ Zip Code: _____	State: _____ Zip Code: _____
Phone Number: Home# _____ Cell/Work# _____	Phone Number: Home# _____ Cell/Work# _____
3. Was your family referred to the Early Head Start Program by another agency? Yes / No Attach letter of referral If yes by whom? _____	
4 a. Does your child have a delay/ disability? Yes / No / Suspected b. Has your child ever been diagnosed/ evaluated? Yes / No If Yes, Where was the diagnosis/ evaluation done? _____	
5. Parental status: One Parent _____ Two Parents _____ Foster _____ Guardian _____	
6. How will your child get to the center-based program? Private car _____ walking _____ day care _____ no transportation _____ other _____	
7. Do you receive TANF? Yes / No If Yes, please give amount: \$ _____ Food Stamps? Yes / No	
8. Does your child receive Medicaid or Private Insurance? Yes / No If Yes, which plan? _____	
9. Has your child received a previous Well Baby/ Child Exam in the past year? Yes / No If yes, when was the last exam? Date: _____ Physician: _____ Has your child received a previous Dental Examination in the past year? If yes, when was the last exam? Date: _____ Dentist: _____	
10. Do you live in NMSU Housing /HUD or subsidized housing? Yes / No If Yes, which one? _____	
11. How many adults live in your household? _____ How many children live in your household? _____	Siblings? _____ Ages? _____ Ages? _____ Other? _____ Ages? _____ Ages? _____
12. Are you a student high school, college or vocational? Yes / No If Yes, where? _____ What degree? GED / Certificate / Associate / Bachelors / Grad. Student Do you receive financial aid or scholarships? Yes / No If Yes, please list: _____	
13. Are you currently employed? Yes / No If Yes, where? _____	How many hours per week? _____
14. Is your spouse currently employed? Yes / No If Yes, where? _____	How many hours per week? _____
15. Is any other person in your home currently employed? Yes / No If Yes, where? _____	How many hours per week? _____
16. Income (list each person's name) _____	Pay Schedule
	(circle one) Weekly 2 weeks 2x Month Monthly
	(circle one) Weekly 2 weeks 2x Month Monthly
	(circle one) Weekly 2 weeks 2x Month Monthly

By signing below, I certify that the information provided is correct to the best of my knowledge and is subject to verification. I am also aware that I may be subject to termination from the program if the information verified disqualifies me from eligibility.

Parent (s) Signature/ Date

Staff Signature/ Title/ Date

Revised 06/10

H: \Eligibility\EHS English application