



Early Head Start Mobile
 Gulf Regional Early Childhood Services
 3100 Cottage Hill Rd. Bld. 4 Suite 400
 Mobile, AL. 36606 251-473-1060

Applicant & Family Member Information

Applicant 1							
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN
Race		Hispanic		English Proficiency		Other Language	Other Language Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes		<input type="checkbox"/> None			<input type="checkbox"/> Poor
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No		<input type="checkbox"/> Little			<input type="checkbox"/> Moderate
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial			<input type="checkbox"/> Moderate			<input type="checkbox"/> Proficient
<input type="checkbox"/> Other: _____				<input type="checkbox"/> Proficient			
Primary Health Coverage		Other Health Coverage		Insurance #	Medicaid	Medicaid #	Doctor
					<input type="checkbox"/> Not Eligible		Dentist
					<input type="checkbox"/> On Medicaid		
					<input type="checkbox"/> Potentially Eligible		

Applicant 2							
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN
Race		Hispanic		English Proficiency		Other Language	Other Language Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes		<input type="checkbox"/> None			<input type="checkbox"/> Poor
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No		<input type="checkbox"/> Little			<input type="checkbox"/> Moderate
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial			<input type="checkbox"/> Moderate			<input type="checkbox"/> Proficient
<input type="checkbox"/> Other: _____				<input type="checkbox"/> Proficient			
Primary Health Coverage		Other Health Coverage		Insurance #	Medicaid	Medicaid #	Doctor
					<input type="checkbox"/> Not Eligible		Dentist
					<input type="checkbox"/> On Medicaid		
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Adult 1							
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN
Race		Hispanic		English Proficiency		Other Language	Other Language Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes		<input type="checkbox"/> None			<input type="checkbox"/> Poor
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No		<input type="checkbox"/> Little			<input type="checkbox"/> Moderate
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial			<input type="checkbox"/> Moderate			<input type="checkbox"/> Proficient
<input type="checkbox"/> Other: _____				<input type="checkbox"/> Proficient			
Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:	
<input type="checkbox"/> Associate's	<input type="checkbox"/> Grade 10	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full Time & Training	<input type="checkbox"/> Natural/Adopted/Step	<input type="checkbox"/> Yes	<input type="checkbox"/> Lives with Family	
<input type="checkbox"/> Bachelor's	<input type="checkbox"/> Grade 11	<input type="checkbox"/> Part Time	<input type="checkbox"/> Part Time & Training	<input type="checkbox"/> Grandchild	<input type="checkbox"/> No	<input type="checkbox"/> Provides Financial Support	
<input type="checkbox"/> Col	<input type="checkbox"/> Grade 12	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Training or School	<input type="checkbox"/> Niece/Nephew			<input type="checkbox"/> Teen Parent
<input type="checkbox"/> Deg/Train	<input type="checkbox"/> < Grade 9	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Foster			If teen parent, subsidized?
<input type="checkbox"/> Col or Adv	<input type="checkbox"/> HS Graduate			<input type="checkbox"/> Other			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Train	<input type="checkbox"/> Master's						
<input type="checkbox"/> GED							

E-mail Address: _____

Adult 2							
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN
Race		Hispanic		English Proficiency		Other Language	Other Language Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes		<input type="checkbox"/> None			<input type="checkbox"/> Poor
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No		<input type="checkbox"/> Little			<input type="checkbox"/> Moderate
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<input type="checkbox"/> Associate's	<input type="checkbox"/> Grade 10	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full Time & Training	<input type="checkbox"/> Natural/Adopted/Step	<input type="checkbox"/> Yes	<input type="checkbox"/> Lives with Family	
<input type="checkbox"/> Bachelor's	<input type="checkbox"/> Grade 11	<input type="checkbox"/> Part Time	<input type="checkbox"/> Part Time & Training	<input type="checkbox"/> Grandchild	<input type="checkbox"/> No	<input type="checkbox"/> Provides Financial Support	
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 Mobile, AL. 36606 (251)473-1060

Additional Child - <i>Is this child also applying for services?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No					Special Needs Child? <input type="checkbox"/> Yes <input type="checkbox"/> No					
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN			
Race					Ethnicity		English Proficiency		Other Language	Other Language Proficiency
<input type="checkbox"/> Asian		<input type="checkbox"/> American Indian/Alaska Native			<input type="checkbox"/> None				<input type="checkbox"/> Poor	
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<input type="checkbox"/> Other: _____					<input type="checkbox"/> Proficient					

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<input type="checkbox"/> White		<input type="checkbox"/> Multi-Racial			<input type="checkbox"/> Moderate				<input type="checkbox"/> Proficient	
<input type="checkbox"/> Other: _____					<input type="checkbox"/> Proficient					

Does your child have Special Needs? ___Yes ___No (If yes, mark below where appropriate)

Does your child have a current IFSP? ___Yes ___No

Do you have a child(ren) enrolled at MCA Head Start? ___Yes ___No

If yes, what site? _____

Diagnosed medical or biological issues currently affecting your child (mark all that apply):

- ___ Asthma (requires medication)
- ___ Autism
- ___ Emotional/Behavioral Disorder
- ___ Learning Disabilities
- ___ Speech/Language Impairment
- ___ Mental Retardation
- ___ Orthopedic Impairments
- ___ Seizures
- ___ Sickle Cell
- ___ Other: _____

If applicant is applying for an **UNBORN** child, please select your current *Trimester*

- ___ 1-3 Months (First Trimester)
- ___ 4-6 Months (Second Trimester)
- ___ 7-9 Months (Third Trimester)

Please provide proof of expected delivery date from your Physician.

Expected due date: ___/___/_____

Other issues you feel should be considered:

___ Suspected disability: _____

Family Information, Income & Contacts

This Section for Agency Use Only:

Applicant Name: _____ Birthday _____

Family Information							
Living Address		Address Line 2	Zip	City	State	County	
Mailing Address (if different)		Address Line 2	Zip	City	State	County	
Phone Numbers		Type (check one)		Note (for example, an extension or best time to call)			
		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other					
		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other					
		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other					
Parental Status (check one)	Primary Language at Home	Homeless Family	Active Duty Military	Referred by Child Welfare Agency	Receiving SNAP	WIC	WIC ID (if applicable)
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Family Income						
TANF			Supplemental Security Income			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Formerly			<input type="checkbox"/> Yes <input type="checkbox"/> No			
Date Verified (agency use only)			Verified by (agency use only)			
Family Member	Amount	Per (for example: week, month, year)	Annual Amount	Description (for example: SSI, Job, Child Support)	Verification (for example: W2, check stub)	Notes
	\$		\$			
	\$		\$			
	\$		\$			
Income Notes						

Emergency Contacts								
Contact 1	Name		Relationship		Emergency Contact		Release To	
					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Address			Zip	City		State	
	Phone # 1			Phone # 2		Phone # 3		
			<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work				<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	
Contact 2	Name		Relationship		Emergency Contact		Release To	
					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Address			Zip	City		State	
	Phone # 1			Phone # 2		Phone # 3		
			<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work				<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	
Contact 3	Name		Relationship		Emergency Contact		Release To	
					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Address			Zip	City		State	
	Phone # 1			Phone # 2		Phone # 3		
			<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work				<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	

Certification: I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent/Guardian Signature _____ Date _____