



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"/> No	<input type="checkbox"/> None	<input type="checkbox"/> Little	<input type="checkbox"/> Moderate	<input type="checkbox"/> Proficient
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Little	<input type="checkbox"/> Moderate	<input type="checkbox"/> Proficient	<input type="checkbox"/> Poor
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial			<input type="checkbox"/> Moderate			<input type="checkbox"/> Moderate
<input type="checkbox"/> Other: _____				<input type="checkbox"/> Proficient			<input type="checkbox"/> Proficient
Primary Health Coverage		Other Health Coverage		Insurance #		Medicaid	Medicaid #
						<input type="checkbox"/> Not Eligible	<input type="checkbox"/> Doctor
						<input type="checkbox"/> On Medicaid	<input type="checkbox"/> Dentist
						<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"/> No	<input type="checkbox"/> None	<input type="checkbox"/> Little	<input type="checkbox"/> Moderate	<input type="checkbox"/> Proficient
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Little	<input type="checkbox"/> Moderate	<input type="checkbox"/> Proficient	<input type="checkbox"/> Poor
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial			<input type="checkbox"/> Moderate			<input type="checkbox"/> Moderate
<input type="checkbox"/> Other: _____				<input type="checkbox"/> Proficient			<input type="checkbox"/> Proficient
Primary Health Coverage		Other Health Coverage		Insurance #		Medicaid	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"/> No	<input type="checkbox"/> None	<input type="checkbox"/> Little	<input type="checkbox"/> Moderate	<input type="checkbox"/> Proficient
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Little	<input type="checkbox"/> Moderate	<input type="checkbox"/> Proficient	<input type="checkbox"/> Poor
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial			<input type="checkbox"/> Moderate			<input type="checkbox"/> Moderate
<input type="checkbox"/> Other: _____				<input type="checkbox"/> Proficient			<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"/> Provides Financial Support
<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"/> Teen Parent	
<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"/> Deg/Train	<input type="checkbox"/> < Grade 9	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Foster			
<input type="checkbox"/> Col or Adv	<input type="checkbox"/> HS Graduate			<input type="checkbox"/> Other			
<input type="checkbox"/> Train	<input type="checkbox"/> Master's					If teen parent, subsidized? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<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
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Additional Child - Is this child also applying for services? Yes No **Special Needs Child?** Yes No

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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
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<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander			<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			

Do you have a child(ren) enrolled at MCA Head Start? ___Yes ___No
If yes, what site? _____

Does your child have Special Needs? ___ Yes ___ No
Does your child have a current IFSP? ___ Yes ___ No (Please provide a copy of current IFSP)
Diagnosed medical or biological issues currently affecting your child (mark all that apply):
 ___Asthma (requires medication) ___Mental Retardation
 ___Autism ___Orthopedic Impairments
 ___Emotional/Behavioral Disorder ___Seizures
 ___Learning Disabilities ___Sickle Cell
 ___Speech/Language Impairment ___Other: _____

Other issues you feel should be considered:
 ___Suspected disability: _____

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)

Expected delivery date: ___/___/___

Please provide proof of expected delivery date from your Physician.

How did you hear about Early Head Start Mobile?
WIC ___ **Health Dept.** ___ **Early Intervention** ___ **Community Action** ___ **Flyers** ___
Friends ___ **Child Care South** ___ **Website** ___ **Other** _____

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		<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		<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		<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 _____