



## SOUTHERN UTE MONTESSORI HEAD START

### APPLICATION / ENROLLMENT INFORMATION

1. The child must be three (3) years old.
2. To begin the application process, please provide the following documentation:
  - A. Completed Application Form
  - B. Child's Birth Certificate
  - C. Proof of income (for both parents if you are two-parent family), which may include **ONE** of the following:
    - ✓ Prior year's income tax form (1040 for the year 2010);
    - ✓ W-2 Forms (2010);
    - ✓ Pay stubs or pay envelopes for prior year (2010);
    - ✓ Written statements from employers for year (2010);
    - ✓ Documentation to show current status as receiving public assistance.
3. After the application packet is received, the Selection Committee will review and determine eligibility status. If your child is selected for our program, please provide the following documentation before enrollment:
  - Proof of child's physical examination
  - Proof of child's immunizations
  - Proof of child's dental examination
  - Medical Insurance Card (Medicaid, CHP+, Private)

Staff will be available to assist you with the completion of this application, if needed. If you have any questions, please call one of our Family Advocates at (970) 563-4566.

# Southern Ute Montessori Head Start Family Demographics Form

Complete this section for each child in the family eligible to receive direct services through Head Start

Child's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
*First name*      *MI*      *Last name*

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Gender:  M  F

Mailing Address: \_\_\_\_\_  
PO Box or Street Apt.#  
\_\_\_\_\_  
City State Zip Code

Home Address: \_\_\_\_\_  
*(If Different)* Street Apt.#  
\_\_\_\_\_  
City State Zip Code

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Ext. #: \_\_\_\_\_

**Race/Ethnicity, If Desired Specify Sub-Category (Mark only one):**

- |   |   |
|---|---|
| <input type="checkbox"/> American Indian-Tribal Affiliation _____ | <input type="checkbox"/> Hispanic or Latino |
| <input type="checkbox"/> Black or African American                | <input type="checkbox"/> White              |
| <input type="checkbox"/> Southern Ute Census Number _____         | <input type="checkbox"/> Asian              |
| <input type="checkbox"/> Southern Ute Descendant                  | <input type="checkbox"/> Other              |

Comments: \_\_\_\_\_

Language(s) Spoken: Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_

English Speaking Ability:  Very Well  Well  Not Well  Not at All

Do you or your pediatrician have any concerns regarding your child's development?  
 Yes  No (Skip to next question)  Don't know (Skip to next question)

Describe Concerns: \_\_\_\_\_

Concerns expressed by:  
 Family Member  Social Service Agency  
 Medical Provider  Other Person or Agency: Specify \_\_\_\_\_

Have there been any significant changes in child's life in the past six months? Describe below.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Southern Ute Montessori Head Start Family Demographics Form

Total Number of Children in Household: \_\_\_\_\_  
 Total Number of Parents/Legal Guardians in Household: \_\_\_\_\_

**Family Type:**

- |  |   |
|--|---|
| <input type="checkbox"/> Two parent family   | <input type="checkbox"/> Other relative(s)                |
| <input type="checkbox"/> Single parent family (mother figure only)                     | <input type="checkbox"/> Foster family                    |
| <input type="checkbox"/> Single parent family (father figure only)                     | <input type="checkbox"/> Other family type: Specify _____ |
| <input type="checkbox"/> Single parent family (mother figure only) living with partner |   |
| <input type="checkbox"/> Single parent family (father figure only) living with partner |   |

**Please List Who Lives in the Home with You and Their Relationship To You**

Family Member Name	Relationship to You

**Are You Living with Other Family Members and/or Friends Due to Economic Hardship?**  Yes  No

**Types of Services or Financial Assistance Received (Mark all that apply):**  No services received

- |  |  |
|--|--|
| <input type="checkbox"/> Medical financial assistance (i.e. Medicaid/Medicare) | <input type="checkbox"/> Supplemental Security Income (SSI) Amount _____ |
| <input type="checkbox"/> Unemployment insurance Amount _____                   | <input type="checkbox"/> Child Support/Alimony Amount _____              |
| <input type="checkbox"/> Food Stamps Amount _____                              | <input type="checkbox"/> Foster Care/Adoption Subsidy Amount _____       |
| <input type="checkbox"/> Public housing assistance                             | <input type="checkbox"/> Energy program assistance (e.g. LEAP)           |
| <input type="checkbox"/> Public Assistance/Welfare (i.e. TANF) Amount _____    | <input type="checkbox"/> Other: Specify _____                            |
| <input type="checkbox"/> WIC   |  |

Name of Mother: \_\_\_\_\_

Name of Father: \_\_\_\_\_

Does mother work?  No  Yes

Does father work?  No  Yes

Place of Employment: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Full-time? \_\_\_\_\_ Part-time? \_\_\_\_\_

Full-time? \_\_\_\_\_ Part-time? \_\_\_\_\_

Is mother in school?  No  Yes

Is father in school?  No  Yes

Full-time? \_\_\_\_\_ Part-time? \_\_\_\_\_

Full-time? \_\_\_\_\_ Part-time? \_\_\_\_\_

Mother's Date of Birth: \_\_\_\_\_

Father's Date of Birth: \_\_\_\_\_

Mother's Highest Level of Education: \_\_\_\_\_

Father's Highest Level of Education: \_\_\_\_\_

Would you prefer a full-day (Monday-Friday 8:30-5:30) or part-day (Monday-Thursday 8:00-1:00) slot? \_\_\_\_\_

I certify that the information provided on this form is accurate and truthful to the best of my knowledge.

Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Parent or Guardian Name: \_\_\_\_\_

Parent or Guardian E-Mail Address: \_\_\_\_\_

\* Only used to inform of activities, school closings, deadline reminders etc.

**AGENCY USE ONLY**

Application Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Income Eligibility: \$ \_\_\_\_\_ # of Adults \_\_\_\_\_ # of Children \_\_\_\_\_

Verifications:  Income  Birth Certificate  Immunizations  Physical  Dental  Insurance Card  
 Other

Staff Signature \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_