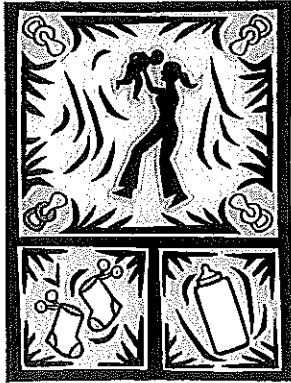


**SOUTHERN UTE MONTESSORI  
EARLY HEAD START PROGRAM**

Serving: Pregnant Women



**APPLICATION INFORMATION**

**PLEASE PROVIDE CONFIRMATION OF DUE DATE BY PHYSICIAN.**

**PROVIDE ANY OF THE FOLLOWING AS PROOF OF INCOME FOR THE YEAR (2010) WITH THE APPLICATION.**

**\*2010 income tax form**

**\*2010 W-2 forms**

**\*Written statement from employers for 2010**

**\*Documentation to show current status as receiving public assistance.**

**STAFF WILL BE AVAILABLE TO ASSIST YOU WITH THE COMPLETION OF THIS APPLICATION, IF NEEDED .PLEASE RETURN THIS APPLICATION WITH THE ABOVE REQUIRED INFORMATION. IT WILL BE REVIEWED BY THE SOUTHERN UTE HEAD START/EARLY HEAD START SELECTION COMMITTEE TO DETERMINE ELIGIBILITY. IF YOU HAVE QUESTIONS, PLEASE CALL, JULIE GOODMAN AT 563-4566.**

Southern Ute Montessori Early Head Start  
Adult Applicant

Complete this section for the parent or other person submitting this application for the family. This section should also be completed if the applicant is a pregnant woman. If applicant is currently pregnant, you may use the PREGNANCY STATUS TRACKING form to supplement information contained in this section.

Applicant Name: \_\_\_\_\_  
First name MI Last name

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

Mother/Mother Figure

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

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

Work Phone: \_\_\_\_\_ Work Phone Ext. \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

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

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

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

English Speaking Ability:  Very well  Well  Not Well  Not at all

Marital Status:  Single  Married  Separated  Divorced  Widowed

Applicant Is Currently Pregnant:  Yes

Primary Occupational Status (Mark only one):  
 Paying job  
 Full-time (more than 34 hours weekly)  
 Part-time  
 Seasonal-Non Agricultural  
 Seasonal-Agricultural  
 Employed and in school

Date: \_\_\_\_\_  
 In job training program  
 Training program with salary  
 Training program without salary  
 Unemployed  
 With past employment experience  
 With no previous employment experience

In school

- Towards high school diploma/GED
- Towards trade/business qualification
- Towards college degree
- Towards postgraduate degree
- In school and employed
- Other

Other

- Homemaker
- Retired
- Unable to work due to disability
- Not Applicable

Highest Level of Education Completed: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Person Previously Enrolled in Head Start or Other Childhood Development Program:

- Yes
- No

If yes, specify which program(s) and date(s) of attendance:

(Use date format: MM/DD/YYYY)

- Early Head Start
- Parent and Child Center (PCC)
- Comprehensive Child Development Program (CCDP)
- Head Start Family Child Care Program
- Head Start Migrant Program
- Head Start Home-based/Home visit for 3 - 5 yr. olds
- Head Start Center-based for 3 - 5 yr. olds
- Other: Specify \_\_\_\_\_

from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
 from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
 from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
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 from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
 from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
 from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Applicant is a Teen Mother:  Yes  No

Applicant Currently an Elementary, Middle or High School Student:  Yes  No

Current level of school:  Elementary  Middle or Junior high  High school

School attended: \_\_\_\_\_

Teen parent program in school attended:  Yes  No

Applicant enrolled teen parent program:  Yes  No

**AGENCY USE ONLY**

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

\* Eligibility Income: \$ \_\_\_\_\_

Funding source/Percentage:  Early Head Start / \_\_\_\_\_ %  State / \_\_\_\_\_ %

Other: Specify \_\_\_\_\_ / \_\_\_\_\_ %

Status: \_\_\_\_\_

Caseload assignment: \_\_\_\_\_ Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Verifications:  Special Needs  DOB: Birth Certificate Number \_\_\_\_\_

Other: Specify \_\_\_\_\_

**Complete one copy of this section for each family applying for Early Head Start services.**

**Family Of:** \_\_\_\_\_

**Total number of children in the household:** \_\_\_\_\_

**Total number of parents/legal guardians in the household:** \_\_\_\_\_

**Family Type:**

- Two parent family
- Single parent family (mother figure only)
- Single parent family (father figure only)
- Single parent family (mother figure only) living with partner
- Single parent family (father figure only) living with partner
- Other relative(s)
- Foster family
- Other family type: Specify \_\_\_\_\_

**Types of Services or Financial Assistance Received (Mark all that apply):**

No services received

- Medical financial assistance (i.e. Medicaid/Medicare)
- Unemployment insurance Amount \_\_\_\_\_
- Food Stamps Amount \_\_\_\_\_
- Public housing assistance
- Public Assistance/Welfare (i.e. TANF/AFDC)\* Amount \_\_\_\_\_
- Energy program assistance
- WIC
- EPSDT
- Supplemental Security Income (SSI)
- Child support/alimony Amount \_\_\_\_\_
- Foster care/Adoption subsidy
- Other: Specify \_\_\_\_\_

**Family Applied to Receive Supplemental Security Income (SSI):**

Yes  No

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

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**AGENCY USE ONLY**

**Referral Source:** \_\_\_\_\_

**Staff Signature:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**SOUTHERN UTE MONTESSORI EARLY HEAD START  
Early Head Start Pregnancy History & Tracking**

Date completed: \_\_\_/\_\_\_/\_\_\_ Name: \_\_\_\_\_

Completed by:       Head Start Staff      Specify: \_\_\_\_\_  
                          Medical Provider      Specify: \_\_\_\_\_

**CURRENT PREGNANCY**

Expected delivery date: \_\_\_/\_\_\_/\_\_\_       Don't know  
Length of pregnancy:  Less than 12 weeks       12-24 weeks       24+ weeks       Don't know  
Month of first prenatal care visit: \_\_\_\_\_       No visit  
Prenatal Care provider:       No Prenatal Care provider

Provider name	Phone #	
Street	Suite #	
City	State	Zip

Prenatal Care:       No prenatal visits  
Date of last prenatal visit: \_\_\_/\_\_\_/\_\_\_      Date of next scheduled exam: \_\_\_/\_\_\_/\_\_\_       No exam scheduled  
Number of Prenatal Care visits since the first: \_\_\_\_\_       Don't remember  
Time since last pregnancy:       No previous pregnancy       Less than 18 months       More than 18 months

**PREVIOUS PREGNANCIES**       No previous pregnancies(end of section)

# of previous pregnancies \_\_\_\_\_

Full-term live births	_____	Multiple gestations	_____
Pre-term live births	_____	Induced abortions	_____
Spontaneous abortions	_____	Ectopic pregnancies	_____
Fetal deaths/stillborns	_____		

**COMMENTS:**