



Youth & Family Services Home-Based Early Head Start



Prenatal Enrollment Application

We are pleased that you are applying for our program! Youth & Family Services Head Start provides a comprehensive program that includes early childhood education, health, nutrition, family partnerships, and advocacy services for enrolled families.

YFS Head Start recognizes parents as the primary educators of their children. Through your involvement in the program, you will have many opportunities to learn and grow with your child. We look forward to sharing the YFS Head Start experience with you and your family!

To complete the enrollment process, YFS Head Start will need the following information:

- ❑ **Completed Application**
(mandatory for enrollment)

- ❑ **Family's Proof of Income**
(mandatory for enrollment)



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EXPECTANT MOTHER'S INFORMATION			
First	Middle	Last	Date of birth
Street		City	
State	Zip	County	
Mailing address (if different than living address)			
Cell phone ()		Home phone ()	Work phone ()
Message phone ()		Email	
What is the due date of your child?		Primary language spoken in your home:	
Race & Ethnicity (please check all that apply): <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi-racial or Bi-racial <input type="checkbox"/> Asian <input type="checkbox"/> Other, please specify: _____			
Are you Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Employment Are you employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where? _____ <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Retired <input type="checkbox"/> Disabled Are you currently attending school or training? If yes, where? _____			
Are you an active member of the U.S Military? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you a veteran of the U.S Military? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Education Highest level completed: <input type="checkbox"/> Grade 9 or less <input type="checkbox"/> Grade 10 <input type="checkbox"/> Grade 11 <input type="checkbox"/> General Education Diploma (GED) <input type="checkbox"/> High School Graduate <input type="checkbox"/> College or Advanced Training <input type="checkbox"/> College Degree/Training certificate <input type="checkbox"/> Associate's Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree			
SECONDARY PARENT/GUARDIAN WHO RESIDES IN HOME (If applicable)			
First	Middle	Last	
Date of birth	Relationship to child		
Cell Phone ()		Home Phone ()	Work Phone ()
Message Phone ()		Email	
Employment Are you employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where? _____ <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Retired <input type="checkbox"/> Disabled Are you currently attending school or training? If yes, where? _____			
Are you an active member of the U.S Military? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you a veteran of the U.S Military? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Education Highest level completed: <input type="checkbox"/> Grade 9 or less <input type="checkbox"/> Grade 10 <input type="checkbox"/> Grade 11 <input type="checkbox"/> General Education Diploma (GED) <input type="checkbox"/> High School Graduate <input type="checkbox"/> College or Advanced Training <input type="checkbox"/> College Degree/Training certificate <input type="checkbox"/> Associate's Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree			
Is this person covered by health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, is health insurance offered/available? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please list all other persons living within your home who are <u>NOT</u> included on the above. If this person is an emergency contact, please add to the Emergency Contact section.			
Name	Relationship	Date of birth	

EMERGENCY CONTACTS			
Persons listed below must be at least 13 years of age. Persons listed will be utilized as alternate points of contact for emergencies. Please try to list at least one.			
Full Name		Relationship to self	
Address	City	State	Zip
Cell Phone ()	Home Phone ()	Work Phone ()	
Full Name		Relationship to self	
Address	City	State	Zip
Cell Phone ()	Home Phone ()	Work Phone ()	
Full Name		Relationship to self	
Address	City	State	Zip
Cell Phone ()	Home Phone ()	Work Phone ()	

ADDITIONAL INFORMATION
<p>What is your current living situation? <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Motel <input type="checkbox"/> Shelter/Mission <input type="checkbox"/> Living with Relatives</p> <p><input type="checkbox"/> Other _____</p> <p>How long have you lived at this address: _____</p> <p>Does your family have access to a reliable means of transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes: <input type="checkbox"/> Private vehicle <input type="checkbox"/> Friend's or relative's vehicle <input type="checkbox"/> Public transportation <input type="checkbox"/> Other _____</p> <p>How many vehicles does your household have? _____</p>
<p>Are there any concerns or family situations that we should be aware of to help meet your needs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe:</p>
<p>Is there a protection/restraining order in effect? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please provide a copy with your application.</i></p>
<p>Does your family receive any of the following types of services or financial assistance?</p> <p>Please check all that apply:</p> <p><input type="checkbox"/> SSI (Supplemental Security Income) <input type="checkbox"/> TANF <i>Please list caseworker: _____</i></p> <p><input type="checkbox"/> SNAP/Food Stamps <input type="checkbox"/> Child Care Assistance <input type="checkbox"/> WIC <input type="checkbox"/> No Services</p>

REQUIRED HEATH AND NUTRITION

Within 30 days of enrollment, a program must determine whether each enrolled pregnant woman has an ongoing source of continuous, accessible health care.

Health/Dental Care Information

- Indian Health Services (IHS) Private Health Insurance No Health Insurance Medicaid/CHIP/Title 19
 IHS Dental Services Private Dental Insurance No Dental Insurance Tricare

Your Doctor:	Name of Clinic:
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Your Dentist:	Name of Clinic:
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- Will the father figure be involved with prenatal visits?** Yes No
Will the father figure be involved with the delivery? Yes No
Will the father figure be involved with the child after birth? Yes No

Do you have concerns about this pregnancy? Yes No
 If yes, please specify: _____

Are these concerns/needs currently met or addressed with your medical provider? Yes No

Is this a high-risk pregnancy? Yes No
 If yes, please explain: _____

Are you on a special diet prescribed by a health care professional or do you restrict foods because of religious preference? Yes No
 If yes, please describe: _____

Are you a diabetic? Yes No

PREVIOUS ENROLLMENT INFORMATION:

Has anyone in your family been previously enrolled in Early Head Start or Head Start? Yes No
 If yes, please mark all that apply:

	Child	Other Family Member
Early Head Start		
Head Start		
YFS Child Development Center		
Non-YFS Program		

How did you hear about our program?

Youth & Family Services Consent Form

Your Name: _____

Please **INITIAL** each of the following items:

	YES	NO	
1.			I authorize Youth & Family Services staff to release my name, telephone number, and/or address to other parents for the purpose of communicating with me about specific program activities.
2.			I authorize Youth & Family Services to include information about me and/or my family in the YFS program newsletter. I understand that the newsletter is distributed to program staff and other enrolled families. This information may include, but is not limited to: me and/or my family name, me and/or my family photographs, me and/or my family achievements or successes, birthdays, and participation in program activities.
3.			I authorize Youth & Family Services to transport me for all program purposes. Youth & Family Services requires seat belt use in all vehicles.
4.			I authorize Youth & Family Services to take photographs/videos of me and/or my family for program use.
5.			I authorize Youth & Family Services to photograph/video me and/or my family. I understand the photographs and footage may be used for the purpose of publicity, illustration, commercial art, and in the advertising of a product or service directly related to Youth & Family Services.
6.			I authorize Youth & Family Services to transfer my child/family records within Youth & Family Services programs in the event that my child/family transfers/participates from one program option to another program option.

Non-Discriminatory Clause: It is the policy of Youth & Family Services to not discriminate on the basis of race, sex, age, color, national origin, or disabilities in the provision of services and employment.

Confidentiality Statement: Information shared with Youth & Family Services will be kept strictly confidential unless its release is authorized in writing.

These forms will be maintained in locked files.

DISCLAIMERS AND SIGNATURE

I hereby release Youth & Family Services from all legal responsibilities or liability that may arise from acts I have authorized above. I would like a copy of this consent form: Yes No

Signature _____ Date _____

I hereby give my consent for Youth & Family Services to provide emergency medical treatment and transportation in the event of a medical emergency. I am aware and understand that I will be responsible for the payment of any medical treatment necessary.

Signature _____ Date _____