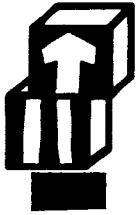


## ***Head Start of Washington County, Inc.***

- ❖ The program is funded to serve 444 pregnant women and children ages 0-5 and their families residing within Washington County.
- ❖ Children and families must meet federal income guidelines for eligibility into the program. Children and families receiving financial assistance, food stamps, and/or other TANF services from the Department of Social Services could be eligible for our program. Families receiving benefits from the Social Security Administration (SSI) are automatically eligible.
- ❖ Our program offers the following options:
  - **Part Day/ Part Year classrooms**
  - **Part Day/ Full Year classrooms**
  - **Full Day/ Full Year classrooms (POC required)**
  - **Home Based Option**
- ❖ Classrooms are located at the following locations:
  - **Martin Luther King Center**  
**131 W. North Ave. (301-797-5231)**
  - **Noland Village Community Center**  
**1048 Noland Dr. (301-797-4602)**
  - **Westshire Center**  
**920 W. Washington St. (301-733-4640)**
  - **Elgin Station Community Center**  
**40 Elgin Blvd. (301-791-7333)**
- ❖ To receive an application, contact or stop by any of the HS centers. You may also contact the enrollment assistant at 301-797-5231 ext. 110.



## **Head Start of Washington County, Inc.** **Proof of Income Documentation**

The following documents are samples that can be used as verification of your family's income:

- W-2 Tax Form
- Copy of actual tax form filed with the IRS
- Dept. of Social Services Award Letter (Food Stamps, TCA)
- Unemployment Benefit Check
- Paycheck Stub (for each different employer in past 12 months)
- Any other documentation that will disclose your income

Please fill out the application and return with Income Documentation to the address on the bottom of the application or to any of the Head Start Sites.



# Head Start of Washington County, Inc.

## ELIGIBILITY AND SELECTION FORM



### Child Information

### Family Information

Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male  Female

Address \_\_\_\_\_  
Street State Zip

Mailing address if different than above \_\_\_\_\_  
Street State Zip

Child's Social Security Number \_\_\_\_\_

Home Phone Number \_\_\_\_\_

If no home number, nearest contact number \_\_\_\_\_

Number of people living in household? Children \_\_\_\_ Adults \_\_\_\_

Child's Primary Language \_\_\_\_\_ Child's Race \_\_\_\_\_

Child lives with:  
 Mother  Father  Both Parents  Foster Parent(s)  Guardian

Does Child have Medical Insurance?  Yes  No

Does child have any special needs?  
What? \_\_\_\_\_

Has child been Diagnosed by a Professional?  
Whom? \_\_\_\_\_

Does your child have an I.E.P./I.F.S.P.?  Yes  No

Please choose one of the following:

- Parent will provide transportation to and from Early Head Start or Head Start site
- Child will use Early Head Start or Head Start Bus Service (if applicable)

Do you have another child(ren) applying for or enrolled in  
Early Head Start or Head Start?  
If yes, what is the child(ren)s name(s)  
\_\_\_\_\_  
\_\_\_\_\_

How did you hear about Head Start?  
\_\_\_\_\_  
\_\_\_\_\_

Female Parent/Guardian \_\_\_\_\_

(if living in the home)

Date of Birth \_\_\_\_\_

Parent's Primary Language \_\_\_\_\_

Parent's Race \_\_\_\_\_

Is Female Parent/Guardian under age 20?  Yes  No

Do you have a Diploma or GED?  Yes  No

Are you currently Pregnant?  Yes  No

Is English your second language?  Yes  No

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

Work Phone Number: \_\_\_\_\_

Male Parent/Guardian \_\_\_\_\_

(if living in the home)

Date of Birth \_\_\_\_\_

Parent's Primary Language \_\_\_\_\_

Parent's Race \_\_\_\_\_

Is Male Parent/Guardian under age 20?  Yes  No

Do you have a Diploma or GED?  Yes  No

Is English your second language?  Yes  No

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

Work Phone Number: \_\_\_\_\_

Marital Status:

- Single  Married  Divorced  Separated  Widowed

Is child currently homeless, living in a shelter or halfway house?  Yes  No

Are three or more children under age 5 living in household?  Yes  No

Does family receive Food Stamp Assistance? (eligibility letter required)  Yes  No

Does family receive SSI Benefits?  Yes  No

Do you receive Child Care Vouchers?  Yes  No

Is child receiving services from another agency?

- The Judy Center  Early Intervention  Healthy Families  The Family Center  Parent Child Center

Parent / Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

★ **PLEASE COMPLETE BOTH SIDES OF THIS FORM** ★

For Office Use Only

Family Number \_\_\_\_\_ Ranking Points \_\_\_\_\_

Mail or Return to:

Head Start of Washington County, Inc.  
131 West North Avenue  
Hagerstown, MD 21740  
(301) 797-5231

For Referral Agency Only

# FAMILY INCOME

## EMPLOYMENT

**Male Parent/Guardian** (if living in home)

Gross Income (Before Taxes) \_\_\_\_\_

Employer's Name \_\_\_\_\_

Employer's Phone Number \_\_\_\_\_

Full Time    No. of Hours \_\_\_\_\_

Part Time    No. of Hours \_\_\_\_\_

Pay Period     Weekly     Bi-weekly

Twice a Month     Monthly     Annually

Year Round?     Yes     No

Seasonal     Yes     No

Please include a copy of your  
paycheck stub(s), W-2 form or 1040

## EMPLOYMENT

**Female Parent/Guardian** (if living in home)

Gross Income (Before Taxes) \_\_\_\_\_

Employer's Name \_\_\_\_\_

Employer's Phone Number \_\_\_\_\_

Full Time    No. of Hours \_\_\_\_\_

Part Time    No. of Hours \_\_\_\_\_

Pay Period     Weekly     Bi-weekly

Twice a Month     Monthly     Annually

Year Round?     Yes     No

Seasonal     Yes     No

Please include a copy of your  
paycheck stub(s), W-2 form or 1040

## OTHER HOUSEHOLD INCOME

If applicable complete information for all that apply to your household.

### SOURCE

### AMOUNT

TANF (TCA)    \$ \_\_\_\_\_

Include certification letter

Social Security/Pension    \$ \_\_\_\_\_

Include letter of eligibility

SSI Benefits    \$ \_\_\_\_\_

Include letter of eligibility

Child Support    \$ \_\_\_\_\_

Weekly     Biweekly     Monthly

Include copy of check or bank statement

Unemployment    \$ \_\_\_\_\_

Weekly     Biweekly

Include copy of unemployment check or check stub

Foster Care Subsidy    \$ \_\_\_\_\_

Include copy of award letter

Other: Specify    \$ \_\_\_\_\_

Include copy of supporting documentation

**No Income (Please read and sign below)**

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

I understand that this form will be used to receive benefits under the federal Head Start program. Providing knowingly false information may be a criminal violation under federal law. By signing this form, I certify and attest that to the best of my knowledge, the information provided on this form is true and accurate.

**Note: All income must be verified.**

**If you receive Food Stamps, a copy of your certification letter must be included.**

### **Complete if there is a second place of employment**

Gross Income (Before Taxes) \_\_\_\_\_

Employer's Name \_\_\_\_\_

Employer's Phone Number \_\_\_\_\_

Full Time    No. of Hours \_\_\_\_\_

Part Time    No. of Hours \_\_\_\_\_

Pay Period     Weekly     Bi-weekly

Twice a Month     Monthly     Annually

Year Round?     Yes     No

Seasonal     Yes     No

Please include a copy of your  
paycheck stub(s), W-2 form or 1040

### **Complete if there is a second place of employment**

Gross Income (Before Taxes) \_\_\_\_\_

Employer's Name \_\_\_\_\_

Employer's Phone Number \_\_\_\_\_

Full Time    No. of Hours \_\_\_\_\_

Part Time    No. of Hours \_\_\_\_\_

Pay Period     Weekly     Bi-weekly

Twice a Month     Monthly     Annually

Year Round?     Yes     No

Seasonal     Yes     No

Please include a copy of your  
paycheck stub(s), W-2 form or 1040

# HEAD START OF WASHINGTON COUNTY PHYSICAL FORM

131 W. North Ave.  
Hagerstown, MD 21740

Phone (301) 797-5231  
Fax (301) 797-5364

CHILD'S NAME: \_\_\_\_\_ SEX: M F BIRTHDATE: \_\_\_\_\_  
 HEAD START CENTER: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 STREET ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

1. RELEVANT INFORMATION: (from Health History, Parent/Teacher Observations)

2. SCREENING TESTS Starred Items (\*) are required by Head Start and recommended by the American Academy of Pediatrics for children ages 3 to 5 years. Enter dates if done previously. When recording results, enter at a minimum "N", "S", or "A" for NORMAL, SUSPECT, OR ATYPICAL/ABNORMAL, respectively.

TEST	DATE	RESULTS	TEST	DATE	RESULTS
a. PRESENT AGE *		Yrs. Mos.	g. VISION *		
b. HEIGHT * <small>(no shoes, to nearest 1/8 in.)</small>			(Type of Test) *		
c. WEIGHT * <small>(light clothing to nearest 1/4 lb.)</small>			ACUITY, R / L		
d. BLOOD PRESSURE			RESCREENING		
e. HEMATOCRIT OR HEMOGLOBIN *			STRABISM US		
f. HEARING * <small>(Type of Test) *</small>			COMMENTS:		
RESULTS, R / L			h. OTHER TESTS (if indicated)		
RESCREENING			(1) TB*		
COMMENTS:			(2) Sickle Cell		
			(3) Lead *		
			12 Months		
			24 months		
			(4) Ova & Parasites		
			(5) Urinary sys		

3. PHYSICAL EXAMINATION / ASSESSMENT Complete and return to HEAD START

	NORMAL FOR AGE	ABNORMAL	NOT EVAL
a. GENERAL APPEARANCE			
b. POSTURE, GAIT			
c. SPEECH			
d. HEAD			
e. SKIN			
f. EYE: (1) External Aspects			
(2) Optic Fundiscopic			
(3) Cover Test			
g. EARS (1) External Aspects			
(2) Tympanic Membranes			
h. NOSE, MOUTH, PHARYNX			
i. TEETH			
j. HEART			
k. LUNGS			
l. ABDOMEN (include hernia)			
m. GENITALIA			
n. BONES, JOINTS, MUSCLES			
o. NEUROLOGICAL/ SOCIAL			
(1) Gross Motor			
(2) Fine Motor			
(3) Communication Skills			
(4) Cognitive			
(5) Self-Help Skills			
(6) Social Skills			
p. GLANDS (lymphatic/Thyroid)			
q. MUSCULAR COORDINATION			
r. OTHER			

s. GENERAL STATEMENT ON CHILD'S PHYSICAL STATUS

4. ABNORMAL FINDINGS, TREATMENTS, AND RECOMMENDATIONS AND FOLLOW-UP

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_

Date : \_\_\_\_\_

Signature: \_\_\_\_\_

**\*BLOOD LEAD LEVELS IS A REQUIRED FIELD\***

DATE OF NEXT WELL CHILD CHECK: \_\_\_\_\_



Head Start requires all areas of this form to be completed.

TO BE COMPLETED BY HEAD START STAFF OR HEALTH CARE PROVIDER BEFORE PHYSICAL EXAMINATION/ASSESSMENT

TO BE COMPLETED BY HEALTH PROVIDER DURING AND AFTER PHYSICAL EXAMINATION/ASSESSMENT

TO BE COMPLETED BY HEAD START STAFF OR HEALTH CARE PROVIDER BEFORE PHYSICAL EXAMINATION/ASSESSMENT

TO BE COMPLETED BY HEALTH PROVIDER DURING AND AFTER PHYSICAL EXAMINATION/ASSESSMENT

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE**

CHILD'S NAME \_\_\_\_\_ LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_

SEX: MALE  FEMALE  BIRTHDATE \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

COUNTY \_\_\_\_\_ SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

PARENT NAME \_\_\_\_\_ PHONE NO. \_\_\_\_\_

OR GUARDIAN ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

**RECORD OF IMMUNIZATIONS (See Notes On Other Side)**

Vaccines Type													
Dose #	DTP-DTaP DT-Td-Tdap Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Heb B Mo/Day/Yr	PCV7 Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV4 Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Vancella Mo/Day/Yr	History of Vancella Disease Mo/Yr
1									1				
2									2				
3										Other	Other	Other	Other
4													
5													

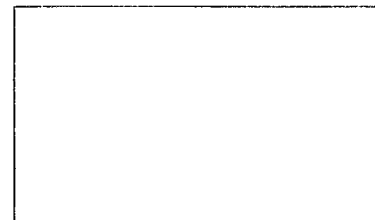
To the best of my knowledge, the vaccines listed above were administered as indicated.

Office Stamp

1. \_\_\_\_\_  
Signature Title Date  
(Medical provider, local health department official, school official, or child care provider only)

2. \_\_\_\_\_  
Signature Title Date

3. \_\_\_\_\_  
Signature Title Date



Lines 2 and 3 are for certification of vaccines given after the initial signature.

**LOST OR DESTROYED RECORDS: (Must be reviewed and approved by a medical provider or the local health department. See notes)**

I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Guardian

**COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.**

**MEDICAL CONTRAINDICATION:**

The above child has a valid medical contraindication to being immunized at this time.

This is a  permanent condition  temporary condition until \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Check appropriate box, indicate vaccine(s) and reasons: \_\_\_\_\_

Signed: \_\_\_\_\_ Date \_\_\_\_\_  
Physician or Health Officer

**RELIGIOUS OBJECTION:**

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child.

Signed \_\_\_\_\_ Date \_\_\_\_\_