

# Enrollment Application

FOR OFFICE USE ONLY
Verified Disability: Yes <input type="checkbox"/> No <input type="checkbox"/>
LS <input type="checkbox"/> MS <input type="checkbox"/> VS <input type="checkbox"/>
Name: _____
Title: _____
Date: _____

**Jefferson-Clarion  
Head Start, Inc.**

Phone: (814)849-3660  
1-800-628-6150  
Fax: (814) 849-6235

**Jefferson-Clarion  
Early Head Start**

Phone: (814)849-3660  
1-800-628-6150  
Fax: (814) 849-6235

**Jefferson-Clarion  
Pre-K Counts**

Phone: (814)849-6758  
1-888-623-7735  
Fax: (814) 849-5684

18 Western Ave., Suite C, Brookville, PA 15825

FOR OFFICE USE ONLY
Date Verified: _____ Pts: _____
Eligibility _____
Early HS <input type="checkbox"/> School Age <input type="checkbox"/> 3 <input type="checkbox"/> 4
Date Enrolled: _____
<input type="checkbox"/> EHS <input type="checkbox"/> HS <input type="checkbox"/> Pre-K
Date Re-Enrolled: _____
Date Withdrawn: _____

**I. PLEASE CHECK WHICH SERVICE YOU ARE APPLYING FOR:**

Children 3 to 5 years: \_\_\_\_\_ Children Birth through 3 Years: \_\_\_\_\_ Pregnant Woman: \_\_\_\_\_

**II. PLEASE ENTER THE INFORMATION FOR THE CHILD OR PREGNANT WOMAN YOU ARE APPLYING FOR:**

A. Child or Pregnant Woman Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_

B. Address: \_\_\_\_\_ County: \_\_\_\_\_ School District: \_\_\_\_\_

C. Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Nearest Phone: \_\_\_\_\_

Email: \_\_\_\_\_

D. Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

E. Child or Pregnant Woman Race/Ethnicity (*Provision of information is voluntary and has no effect on determination of eligibility*)

**Race:** \_\_\_\_\_ American Indian or Alaskan Native \_\_\_\_\_ Asian \_\_\_\_\_ Black/African American

\_\_\_\_\_ Native Hawaiian or Pacific Islander \_\_\_\_\_ White \_\_\_\_\_ Bi-Racial

**Ethnicity:** \_\_\_\_\_ Hispanic/Latino Origin \_\_\_\_\_ Non-Hispanic/Non-Latino Origin

**III. CHILD'S PARENTS/LEGAL GUARDIANS OR PREGNANT WOMAN'S SPOUSE INFORMATION:**

Name	Date of Birth	Social Security #	Education Level (Grade, GED, Post-Secondary)
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Name	Date of Birth	Social Security #	Education Level (Grade, GED, Post-Secondary)
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A. Child lives with: \_\_\_\_\_ Both Parents \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Foster Family \_\_\_\_\_ Other (Relationship)

B. Other children residing at home:

Name	Date of Birth	Name	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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