

Head Start Family Demographics Form

SECTION 1: ELIGIBLE CHILD

Complete this section for each child in the family eligible to receive direct services through Head Start or other early childhood programs run by your agency.

Child's Name: _____ **Nickname:** _____
First name MI Last name

Date of Birth: _____ **SSN:** _____ - _____ - _____ **Gender:** M F

Address: _____
Street Apt.#

City State Zip Code

Telephone: _____ Area: _____

(Mark all that apply)

Living Mailing Pick-up Drop-off Other: Specify _____

Other Address: _____
(If applicable) Street Apt.#

City State Zip Code

Telephone: _____ Area: _____

(Mark all that apply)

Living Mailing Pick-up Drop-off Other: Specify _____

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

<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Sub-Category _____	<input type="checkbox"/> Asian <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> White
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Comments: _____

Language(s) Spoken: Primary: _____ Secondary: _____

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

Do you have any concerns about your child's overall health and development in the following areas or does your child have a disability in any of these areas? If so, check appropriately.

	Suspected	Identified	Date	Evaluated by:
Autism	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
Emotional/behavior disorder	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
Health impairment	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
Hearing impairment including deafness	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____

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	Suspected	Identified	Date	Evaluated by:
Learning disability	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
Orthopedic impairment	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
Speech or language impairment	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
Traumatic brain injury	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
Visual impairment including blindness	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
Other impairment: _____	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____

Are any of the following assistive devices used? (mark all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> No assistive devices | <input type="checkbox"/> Glasses/contact lenses | <input type="checkbox"/> Crutches/walker/cane |
| <input type="checkbox"/> Braces | <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Hearing Aide |
| <input type="checkbox"/> Other: Specify: _____ | | |

Parent report and records indicate no disabilities.

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

- Yes No (*Skip to next question*)

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

(Use the date format: MM/DD/YYYY)

- | | | | | |
|--|------|-------------|----|-------------|
| <input type="checkbox"/> Early Head Start | from | ___/___/___ | to | ___/___/___ |
| <input type="checkbox"/> Parent and Child Center (PCC) | from | ___/___/___ | to | ___/___/___ |
| <input type="checkbox"/> Comprehensive Child Development Program (CCDP) | from | ___/___/___ | to | ___/___/___ |
| <input type="checkbox"/> Head Start Family Child Care Program | from | ___/___/___ | to | ___/___/___ |
| <input type="checkbox"/> Head Start Migrant Program | from | ___/___/___ | to | ___/___/___ |
| <input type="checkbox"/> Head Start Home-based / Homevisit for 3 - 5 yr olds | from | ___/___/___ | to | ___/___/___ |
| <input type="checkbox"/> Head Start Center-based for 3 - 5 yr olds | from | ___/___/___ | to | ___/___/___ |
| <input type="checkbox"/> Other: Specify _____ | from | ___/___/___ | to | ___/___/___ |

If your child will need full day service (more than 6 hours per day) check all that applies to your family:

- parents are employed;
- parents are in school
- parents are in job training; with no caregiver present in the home
- parent/child with special needs
- other (describe) _____

Will child be Cared For By Someone Other Than the Head of Household after leaving Head Start:

- Yes No

If yes, specify Day Care Provider(s) (Mark all that apply):

- Receive care at a family child care home
- Receives care at a Child Care center or classroom
- Receives care at home or at another home with relative or unrelated adult
- Receives care through a public school pre-kindergarten program
- Other: Specify _____

Head Start Family Demographics Form
SECTION 1: ELIGIBLE CHILD

AGENCY USE ONLY

Application Date: ___/___/___ Enrollment Date: ___/___/___ Withdrawal: ___/___/___

Program Applying for: HEAD START or EARLY HEAD START

Program Type: FULL DAY or FULL DAY/FULL YEAR

Center Applying for: _____

Class Applying for: _____

Funding Source/Percentage: Federal / _____% State / _____%

Other: Specify _____ / _____%

Status: _____

Caseload Assignment: _____ Start Date: ___/___/___ End Date: ___/___/___

Verifications: Special Needs Birth Certificate Immunization Record

Social Security Card Other: Specify _____

Signature/Title of Head Start Staff

Date

Head Start Family Demographics Form

SECTION 2: FAMILY MEMBERS

Complete this section for all family members not included in Section 1. List the Head of Household first. Note: If the family member is eligible for services under another Head Start or other early childhood program run by your agency, complete Section 1 in lieu of this section.

Person's Name: _____
First name MI Last name

Mother/Mother Figure Father/Father Figure None of the Above

Person is a Supporting Adult in the Child(ren)'s Life: Yes No

Person is the Head of Household for this family:

Yes No

Person resides in the same household with the Head of Household:

Yes, all of the time No, never
 Yes, some of the time

Date of Birth: _____ SSN: _____ - _____ - _____ Gender: M F

Work Phone: _____ Work Phone Ext. _____ Message Phone: _____

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

- | | |
|--|---|
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Hispanic or Latino |
| <input type="checkbox"/> Native Hawaiian or other Pacific Islander | <input type="checkbox"/> White |
| <input type="checkbox"/> Sub-Category _____ | |

Comments: _____

Language(s) Spoken: Primary: _____ Secondary: _____

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

Person is Currently Pregnant: Yes: Due Date _____ No Not Applicable

Person's Relationship to the Eligible Child(ren) Listed in Section 1:

Eligible Child Name: _____

Relationship to Child: _____

Eligible Child Name: _____

Relationship to Child: _____

Eligible Child Name: _____

Relationship to Child: _____

Head Start Family Demographics Form

SECTION 2: FAMILY MEMBERS

Primary Occupational Status (*Mark only one*): _____ Date: _____

- Paying job
 - Full-time (more than 34 hours weekly)
 - Part-time
 - Seasonal-Non Agricultural
 - Seasonal-Agricultural
 - Employed and in school
- In school
 - Towards high school diploma/GED
 - Towards trade/business qualification
 - Towards college degree
 - Towards postgraduate degree
 - In school and employed
 - Other
- In job training program
 - Training program with salary
 - Training program without salary
- Unemployed
 - With past employment experience
 - With no previous employment experience
- Other
 - Homemaker
 - Retired
- Unable to work due to disability
- Not Applicable

Highest Level of Education Completed: _____ Date Completed: _____

Attended Vocational Training, Trade or Business School:
Received certificate or license: Yes No (*Skip to next question*)
 Yes No

Participated in Government Training Program:
Training program(s) attended (*Mark all that apply*):
 JOBS JTPA Job Corps Yes No (*Skip to next question*)
 Other: Specify _____

Person is Willing to Pursue Additional Education/Job Training: Yes No Not Applicable

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)*

<input type="checkbox"/> Early Head Start	from	___/___/___	to	___/___/___
<input type="checkbox"/> Parent and Child Center (PCC)	from	___/___/___	to	___/___/___
<input type="checkbox"/> Comprehensive Child Development Program (CCDP)	from	___/___/___	to	___/___/___
<input type="checkbox"/> Head Start Family Child Care Program	from	___/___/___	to	___/___/___
<input type="checkbox"/> Head Start Migrant Program	from	___/___/___	to	___/___/___
<input type="checkbox"/> Head Start Home-based/Home visit for 3 - 5 yr. olds	from	___/___/___	to	___/___/___
<input type="checkbox"/> Head Start Center-based for 3 - 5 yr. olds	from	___/___/___	to	___/___/___
<input type="checkbox"/> Other: Specify _____	from	___/___/___	to	___/___/___

Head Start Family Demographics Forms
SECTION 3: FAMILY COMPOSITION AND RESOURCES

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

Family Of: _____

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 _____

of Adults _____ **# of Child(ren)** _____

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

Must provide documentation of all services checked receiving.

- | | |
|--|--|
| <input type="checkbox"/> Medical financial assistance (i.e. Medicaid/Medicare) | <input type="checkbox"/> Unemployment insurance |
| <input type="checkbox"/> Food Stamps | <input type="checkbox"/> Public housing assistance |
| <input type="checkbox"/> Public Assistance/Welfare (i.e. TANF/AFDC)* | <input type="checkbox"/> Energy program assistance |
| <input type="checkbox"/> WIC | <input type="checkbox"/> EPSDT |
| <input type="checkbox"/> Supplemental Security Income (SSI) | <input type="checkbox"/> Child support/alimony |
| <input type="checkbox"/> Foster care/Adoption subsidy | <input type="checkbox"/> CHIPs (Child Health Ins. Program) |
| <input type="checkbox"/> Help with incarcerated family members | <input type="checkbox"/> Private Insurance |
| <input type="checkbox"/> Title V services | <input type="checkbox"/> Other: Specify _____ |

*** If Family is Receiving Public Assistance (TANF or SSI), Answer the Following:**

Began receiving services: ____/____/____ **Scheduled termination:** ____/____/____

Family Applied to Receive Supplemental Security Income (SSI): Yes No

Housing Payment Arrangement:

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Own housing | <input type="checkbox"/> Exchange services for housing | <input type="checkbox"/> Receive subsidized housing |
| <input type="checkbox"/> Rent housing | <input type="checkbox"/> Make no payment for housing | <input type="checkbox"/> Other: Specify _____ |

Type of Housing:

- | | | | |
|------------------------------------|--|--|--|
| <input type="checkbox"/> House | <input type="checkbox"/> Mobile home/trailer | <input type="checkbox"/> Homeless/no housing | <input type="checkbox"/> Migrant Housing |
| <input type="checkbox"/> Apartment | <input type="checkbox"/> Community shelter | <input type="checkbox"/> Hotel/motel room | <input type="checkbox"/> Other: _____ |

Length of Time at Current Address:

- | | |
|---|--|
| <input type="checkbox"/> Less than 6 months | <input type="checkbox"/> 1 - 2 years |
| <input type="checkbox"/> 6 - 12 months | <input type="checkbox"/> More than 2 years |

Number of Times Family Moved in the Past 12 Months:

- | | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> Family has not moved | <input type="checkbox"/> Twice | <input type="checkbox"/> Four or more times |
| <input type="checkbox"/> Once | <input type="checkbox"/> Three times | |

Homeless in Past 12 Months (Including currently homeless): Yes No (Skip to next question)

Length of time homeless:

- | | |
|--|---|
| <input type="checkbox"/> Less than 1 month | <input type="checkbox"/> 3 - 6 months |
| <input type="checkbox"/> 1 - 3 months | <input type="checkbox"/> More than 6 months |

Head Start Family Demographics Forms
SECTION 3: FAMILY COMPOSITION AND RESOURCES

AGENCY USE ONLY

Family Income: (Check \checkmark all that were used in determining family's total income)

1040 \$ _____
 Public Assistance(TANF) \$ _____
 Income declaration \$ _____
 Social Security \$ _____
 Child Support \$ _____

W-2 \$ _____
 Check stub \$ _____
 Unemployment \$ _____
 SSI \$ _____
 Other: Specify _____
\$ _____

Total Income \$ _____ + Number in Family _____ = \$ _____ per family unit

Number of adults contributing to this income _____

The above income is based on the time period for: Previous 12 months Last Calendar Year

Referral Source: _____

Staff Signature _____ Date ____/____/____

Family Research Classification:

- Program Family Comparison Family
 Not Part of Research Study