Mayville State University
Child Development Programs

Application for Head Start/Early Head Start Program

Attached you will find a copy of the application for enrollment. Please complete the entire application sign, date and return in the enclosed business reply envelope. Enrollment is based on the child's age and the family's income. In order to complete the application process the following information needs to be submitted:

- ☐ Complete Application Form
- ☐ Copy of your Child's Birth Certificate
- ☐ Copy of Income Verification

  (Income Tax Form 1040 or W2 forms from previous tax year, pay stubs, written statement from employer, disabilities benefit, letter showing current status of public assistance, foster care payments or financial aid statements.)

A percentage of over-income families may be accepted each year depending on the income levels of other applicants. If you feel your family will not fall within the Federal income guidelines, please still complete the application process.

Within 7-10 days of the enrollment office's receipt of your completed application packet, you will be notified by phone, mail or email to inform you of the status of your family's application. If the all supporting documentation is not submitted with the application, your family will not be put on the waiting list until it is received.

Thank you for taking the time to apply for the Mayville State University Child Development Head Start/Early Head Start Programs. We look forward to receiving your application for review. If you have any questions or need any assistance with completing the application process, please email me at Amanda.Domier@mayvillestate.edu (which is the most efficient way) or call at 800.437.4104 Ext 34868 or 701.788.4868.

Sincerely,

Mandi Domier
Enrollment & Transportation Coordinator

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Mayville State University
Child Development Programs

Head Start Early Head Start Application for Enrollment

Applicant Information (Child or Expectant Mother)

Applicant1

First Name	*Middle Initial*	*Last Name*	
Date of Birth	*Social Security #*	*Gender*	*Due Date (expectant mother)*
Race	*Native Country*	*Primary Language*	*Secondary Language*

Applicant2

First Name	*Middle Initial*	*Last Name*	
Date of Birth	*Social Security #*	*Gender*	*Due Date (expectant mother)*
Race	*Native Country*	*Primary Language*	*Secondary Language*

Applicant3

First Name	*Middle Initial*	*Last Name*	
Date of Birth	*Social Security #*	*Gender*	*Due Date (expectant mother)*
Race	*Native Country*	*Primary Language*	*Secondary Language*

Address (where the applicants are living) *What is the primary language at home?* _____

Street	*Town*	*State*	*Zip Code*	*County*

Mailing Address *(if different)*

Street	*Town*	*State*	*Zip Code*	*County*

Telephone Numbers/Email

Home	*Who should we call first?*		
Cell (Mother)	*Work (Mother)*	*Cell (Father)*	*Work (Father)*
Email address (mother)		*Email address (father)*	

Have any of the applicants been diagnosed with any of the following impairments or disabilities that would require special education and related services?

Applicant1	**Applicant2**	**Applicant3**
☐ Autism	☐ Autism	☐ Autism
☐ Emotional/Behavior (ADD/ADHD)	☐ Emotional/Behavior (ADD/ADHD)	☐ Emotional/Behavior (ADD/ADHD)
☐ Health	☐ Health	☐ Health
☐ Hearing (including Deafness)	☐ Hearing (including Deafness)	☐ Hearing (including Deafness)
☐ Learning Disability	☐ Learning Disability	☐ Learning Disability
☐ Mental Retardation	☐ Mental Retardation	☐ Mental Retardation
☐ Multiple Disabilities	☐ Multiple Disabilities	☐ Multiple Disabilities
☐ Non-categorical Developmental Delay	☐ Non-categorical Developmental Delay	☐ Non-categorical Developmental Delay
☐ Orthopedic	☐ Orthopedic	☐ Orthopedic
☐ Speech or Language	☐ Speech or Language	☐ Speech or Language
☐ Traumatic Brain Injury	☐ Traumatic Brain Injury	☐ Traumatic Brain Injury
☐ Visual (including Blindness)	☐ Visual (including Blindness)	☐ Visual (including Blindness)
☐ Other :	☐ Other :	☐ Other :
☐ None diagnosed or suspected	☐ None diagnosed or suspected	☐ None diagnosed or suspected
Date of diagnose and any explanation	*Date of diagnose and any explanation*	*Date of diagnose and any explanation*
Site Option	***Site Option***	***Site Option***
☐ Mayville ☐ Hillsboro	☐ Mayville ☐ Hillsboro	☐ Mayville ☐ Hillsboro
☐ HPK (MWF) ☐ Central Valley	☐ HPK (MWF) ☐ Central Valley	☐ HPK (MWF) ☐ Central Valley
☐ Home-Based ☐ McVille	☐ Home-based ☐ McVille	☐ Home-based ☐ McVille
☐ Unsure ☐	☐ Unsure ☐	☐ Unsure ☐

Which of the following best describes the applicant's family (check one):

☐ Two parent family (married or common law)
☐ Single parent (father or father figure only)
☐ Single parent (mother or mother figure only)
☐ Teenage living at home with parents
☐ Foster family
☐ Single parent (father/father figure) living with partner
☐ Single parent (mother/mother figure) living with partner
☐ Other :

# of adults (18 years and older) in your household: _____

# of children (under 18 years old) in your household: _____

What is the primary health coverage:

Family Information

Primary Adult

First Name	*Last Name*	*Living with Family*	*Teen Parent*
Date of Birth	*Social Security #*	*Gender*	*Occupation*
Race	*Native Country*	*Primary Language*	*Secondary Language*
Provide financial support to applicant		*Custody*	

Secondary Adult

First Name	*Last Name*	*Living with Family*	*Teen Parent*
Date of Birth	*Social Security #*	*Gender*	*Occupation*
Race	*Native Country*	*Primary Language*	*Secondary Language*
Provide financial support to applicant		*Custody*	

Other Adult

First Name	*Last Name*	*Living with Family*	*Teen Parent*
Date of Birth	*Social Security #*	*Gender*	*Occupation*
Race	*Native Country*	*Primary Language*	*Secondary Language*
Provide financial support to applicant		*Custody*	

Sibling1

First Name	*Last Name*	*Date of Birth*	*Gender*
Does child live at home	*Has this child previously been enrolled in EHS or HS?*		*If yes when & where?*

Sibling2

First Name	*Last Name*	*Date of Birth*	*Gender*
Does child live at home	*Has this child previously been enrolled in EHS or HS?*		*If yes when & where?*

Sibling3

First Name	*Last Name*	*Date of Birth*	*Gender*
Does child live at home	*Has this child previously been enrolled in EHS or HS?*		*If yes when & where?*

Sibling4

First Name	*Last Name*	*Date of Birth*	*Gender*
Does child live at home	*Has this child previously been enrolled in EHS or HS?*		*If yes when & where?*

Does your family receive any of the following types of services or assistance?

Type of Service or Assistance	When did you begin receiving services? Where are you receiving services from? What is your case number?
☐ Child Care Assistance	
☐ Energy Assistance Program	
☐ Enrolled in high school, college or other training program	
☐ Even Start or other literacy program	
☐ Food Stamps	
☐ Foster care/Adoption subsidy	
☐ Healthy Tracks	
☐ Homeless	
☐ Medical Financial Assistance (Medicaid/Medicare)	
☐ Pro Work Program	
☐ Public Assistance/Welfare (TANF)	
☐ Public Housing Assistance	
☐ Supplemental Security Income (SSI)	
☐ Unemployment Insurance	
☐ WIC	
☐ Other	
☐ None	

Is your family experiencing a crisis or unmet family need at this time?

☐ *Yes* ☐ *No* *If yes, please explain?* _____

Please let us know how you heard about our program!

_____

Applicant/Parent/Guardian

_____ _____

Signature *Date*

(Office Use Only) Date Received: