Early Head Start
2L & 2M Estate
Concordia (East)
Mail: PO Box 866
Frederiksted VI 00841
(340) 773-4006
Fax: (340) 719-4507

Early Head Start
Queen Louise Home for Children
71 Estate Concordia (West)
Mail: PO Box 866
Frederiksted VI 00841
(340) 772-0090
Fax: (340) 772-0716

EARLY HEAD START APPLICATION

Dear Applicant:

The Early Head Start Program is designed for pregnant women and children birth to three years of age. Our primary goal is to provide comprehensive services that give children the opportunity to realize their full potential. Children receive educational and developmental support services at the Early Head Start Center or through the Home-Based program that is provided free of charge to the family. The program provides experiences that all family members are encouraged to attend.

Below is a list of documentation that is needed by the Early Head Start Program in order to process your application. Please bring these items with the completed application to either one of the following Early Head Start locations: Queen Louise Home Campus at 71 Estate Concordia in Frederiksted, St. Croix or 2L & 2M Estate Concordia in Kingshill, St. Croix.

If you have any questions, please feel free to contact Early Head Start at 340-772-0090 Ext. 39 or 340-773-4006 Ext. 3. Thank you for your interest in the Early Head Start Program.

_____ COMPLETED APPLICATION

_____ PROOF OF INCOME: To be considered for the program, we must have reasonable verification of 12 months of income for the previous year, for your total family. Verification of all income earned in the previous year is required. Failure to disclose this information may disqualify your application for consideration.

Prior Year W2 / 1040 Form or
2 check stubs from December showing Year To Date Income
Letter from DHS (if applicable)
Letter of support (if applicable)
Income Verification Form (provided upon request if none of the above apply)

_____ PROOF OF IDENTITY
Birth certificate for child and
Government issued Photo I.D. for parent/guardian

_____ PROOF OF RESIDENCE
Current Lease Agreement
Current Utility bill (WAPA)
Note: If the utility at your residence is not billed in your name, you must also submit a dated and signed letter from the owner of the residence acknowledging that you reside at the referenced address.

_____ PROOF OF DISABILITY (if applicable)

_____ PROOF OF PREGANCY (when applying for the Pregnant Woman Program)

Application will not be processed until required items are received

Lutheran Social Services of the V.I., Inc. is an equal opportunity provider and employer.

Staff Use Only
Date Received:________
Date Enrolled:________
Other: _______________

LUTHERAN SOCIAL SERVICES OF THE VIRGIN ISLANDS

EARLY HEAD START APPLICATION

Please complete all application sections for the program option you are applying for to ensure the application is processed accurately.

PROGRAM OPTION: Mark which option(s) best fits your needs.

_____Pregnant Women Program   _____Center-Based Program   _____Home-Based Program

PREGNANT WOMEN PROGRAM - EXPECTANT MOTHER:

Last Name:	D.O.B: ____/____/____	SSN: ____/____/____
First Name:	Current Age:	Gender:
Head of Family (If Minor):	D.O.B: ____/____/____	Gender:
Physical Address:	Mailing Address (if different):	
Ethnicity of Family:	Primary Language:	
Highest Education Level Achieved:	Currently in school? ____Yes ____No If yes, where?_______________ F/T or P/T? ____	
MEDICAL INFO: Expectant Due Date: ____/____/____ Is your pregnancy considered high risk? ____Yes ____No Doctor's Name: __________________ Office or Clinic Visited: __________________ Office Phone #: __________________ How many times have you been seen? ______________ Approximate last visit? _______________	Home Phone #: ______________________ Cell #: ______________________ Other: ______________________	
Do you have reliable transportation? ___Yes ___No Do you feel you will need transportation assistance to participate in socialization events? ___Yes ___No		

CENTER/HOME-BASED SERVICES - CHILD & FAMILY INFORMATION:

<table>
<tr><td>Child's Name:</td><td>D.O.B: ____/____/____</td><td>Gender:</td></tr>
<tr><td>Mother's Name:
Lives in household with child? ____Yes ____No
Highest Education Level Achieved: _______________
Enrolled in School or Job Training? ____Yes ____No</td><td>D.O.B: ____/____/____</td><td>Marital Status:
S M D SEP</td></tr>
<tr><td>Father's Name:
Lives in household with child? ____Yes ____No
Highest Education Level Achieved: _______________
Enrolled in School or Job Training? ____Yes ____No</td><td>D.O.B: ____/____/____</td><td>Marital Status:
S M D SEP</td></tr>
<tr><td>Ethnicity of Family:</td><td colspan="2">Primary Language:</td></tr>
<tr><td>Child's Physical Address:</td><td colspan="2">Mailing Address (if different):</td></tr>
<tr><td colspan="3">Home Phone #: _______________________ Cell #: ___________________ Other: _________________________</td></tr>
<tr><td colspan="3">Please list any individual who retains <u>legal</u> parental rights.</td></tr>
<tr><td colspan="3">Do you or a family member in the home have reliable transportation? ___Yes ___No
If no, how will your child get to the Early Head Start Center? ____________________________</td></tr>
</table>

INCOME INFORMATION:

<table>
<tr><td>Applicant or Head of Household Employment Status: (Check which apply)
_____Employed Where?______________________________ Hourly Wage: _____________
_____Unemployed Receive unemployment? ___Yes ___No How Much? _____________</td></tr>
<tr><td>Gross Annual Income: $_____________
Other Assistance Currently Receiving? ___Yes ___No
If yes, which of the following?
_____SSI _____Child Support _____ Foster Care _____Public Housing _____Food Stamps
_____MAP _____WIC _____TANF _____BLOCK Grant Other __________________________
List any services pending: ____________________________________</td></tr>
</table>

OTHER FAMILY INFORMATION (all program options):

Do any of the following situations apply to you currently or in the past year?

_____Domestic violence in home

_____Incarceration of one or both parents

_____Parent of applicant is in foster care

_____Applicant is in foster care

_____Other children in family are in foster care

_____Received services for substance abuse

_____Homeless or lived in shelter

_____Received assistance from DHS

_____Received assistance from Women's Coalition

_____Received assistance from Court Appointed Services

_____Received assistance from other non-profit agency

_____Parent has a disability? If yes, list agency(s) providing services: ___________________________________

_____Applicant has a disability? If yes, list agency(s) providing services:_______________________________

How many times have you moved in the last year? ______

Is anyone in the household a veteran? ___Yes ___No

If yes, list name: _______________________________

Are you or your child a relative of an Early Head Start employee? ___Yes ___No

Is yes, please state the name and the relationship: ____

OTHER FAMILY MEMBERS IN HOUSEHOLD (all program options):

Last Name	First Name	Relationship	Age	Gender	Ed. Level

I certify that the information provided in this application is accurate and truthful to the best of my knowledge. I understand that incorrect information given by me in this form may lead to my dismissal from the program. I hereby agree to limit any and all claims I may have against Lutheran Social Services / Early Head Start insurance. I understand that I must provide proof of income before my child or I can be considered for the program.

____ ______________________

Signature of Applicant / Parent or Guardian Date

____ ______________________

Signature of EHS Staff Date

Lutheran Social Services of the Virgin Islands

Early Head Start

Parent/Guardian Program Eligibility Certification

Name of Parent/Guardian ________________________________ Date ___/___/____

Childs Name _______________________________ D.O.B. ______________________

I __________________________________, am seeking the services offered by Early Head Start. I certify, to the best of my knowledge, that the documents and information that I am providing concerning eligibility are accurate and true.

I understand that any information found to be inaccurate, falsified or untrue will make my application ineligible for review and possible selection for receipt of services provided by Early Head Start.

I also understand that if I am selected to receive services provided by Early Head Start, that any information found to be inaccurate, falsified or untrue, at any time during the school year, will disqualify my child from receiving Early Head Start services.

Signature ____ Date ___/___/____