EARLY HEAD START APPLICATION (PREGNANT WOMAN PROGRAM)

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**
Government issued Photo I.D.

_____ **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 DOCUMENT**

Application will not be processed until required items are received

USDA Nondiscriminatory Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Staff Use Only
Date Received:_____
Date Enrolled:_____
Other: _____

LUTHERAN SOCIAL SERVICES OF THE VIRGIN ISLANDS

EARLY HEAD START APPLICATION

PREGNANT WOMAN PROGRAM

Application # _____

To ensure this application is processed accurately, please complete all application sections for the program option you are applying for.

PREGNANT WOMEN PROGRAM

Last Name:	D.O.B: ____/____/____	Current Age:
First Name:	Head of Family (If Minor):	
Physical Address:	Mailing Address (if different):	

Primary Language of the Family at Home

____ English ____ Spanish ____ Native Central American, South American, Mexican Languages ____ Caribbean Languages	____ Middle Eastern & South Asian Languages ____ East Asian Languages ____ Native North American - Alaska Native Languages	____ Pacific Island Languages ____ African Languages ____ Other ____ Unspecified
Please check one: ____ Hispanic or Latino Origin		____Non-Hispanic or Non-Latino-Origin

Please check one of the following:

____ American Indian or Alaska Native	____ Asian	____ Biracial or Multi-Racial
____ Black or African American	____ Native Hawaiian or Other Pacific Islander	____ Other
____ White	____ Unspecified	

Highest Education Level Achieved:	Currently in school? ____Yes ____No If yes, where?_____ F/T or P/T? ____

MEDICAL: Expected Due Date: ____/____/____ Doctor's Name: _____ Office or Clinic Visited: _____ Office Phone #: _____ How many times have you been seen by your doctor? _____ Approximate date of last visit? _____	Home Phone #: _____ Cell #: _____ Other: _____ Do you have reliable transportation? ___Yes ___No Do you feel you will need transportation assistance to participate in Early Head Start events? ___Yes ___No

INCOME INFORMATION:

Applicant or Head of Household Employment Status: (Check which apply)

_____Employed Where?_____ Hourly Wage: _____

_____Unemployed Receive unemployment? ___Yes ___No How Much? _____

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: _____

OTHER FAMILY INFORMATION

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

_____Received assistance from Department of Human Services

_____Received assistance from Women's Coalition

_____Received assistance from Court Appointed Services

_____Received assistance from other non-profit agency

_____If the parent has a disability, please list any agency(ies) 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/children a relative of an Early Head Start employee? ___Yes ___No

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

OTHER FAMILY MEMBERS IN HOUSEHOLD:

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.

Applicant Signature: _____ Date: _____

EHS Signature: _____ Date: _____

DO NOT FILL OUT BELOW THIS LINE

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Date Application Received By Early Head Start

EHS Signature: _____ Date: _____

Applicant Signature: _____ Date: _____

LUTHERAN SOCIAL SERVICES OF THE VIRGIN ISLANDS

EARLY HEAD START

Parent/Guardian Program Eligibility Certification

Parent Name _____ Date ___/___/_____

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 ___/___/____

Application Number _____

Please answer the following questions as applicable:	YES	NO
1) Is the child you are applying for homeless, in foster care, or in the custody of Child Protective Service (Department of Human Services?)		
2) Were you referred to Early Head Start by a Child Protective Service Agency (Department of Human Services?)		
3) Is your family homeless?		
4) Has your family been homeless in the past year, or have lived in a shelter?		
5) Do you have other children currently in foster care?		
6) Is either parent incarcerated or has been incarcerated within the last year?		
7) Does your child have an identified disability? If yes, attach documentation		
8) Does either parent have an identified disability? If yes, attach documentation		
9) Are you a single parent and unemployed?		
10) Are both parents unemployed?		
11) Are you a working parent in a college or trade school more than 20 hours per week?		
12) Are you a working parent in a college or trade school less than 20 hours per week?		
13) Are you a teenage parent?		
14) Are you a parent below 21 years of age?		
15) Are you a teenage parent currently in foster care?		
16) Are you or a family member receiving services for substance abuse (or has received this service within the past year?)		
17) Is there a family history of violence?		
18) Is your education level below a HS diploma or GED?		
19) Is your pregnancy if applicable considered high risk? (must provide documentation)		
20) Has either parent experienced the death of a child?		
21) Does either parent have a current or history of gambling addiction?		
22) Is either parent primary language another language besides English?		
23) Do you have another child enrolled in EHS in the previous year?		
24) Is either parent on active duty in the military?		
25) **EHS STAFF ONLY:** Income equal or less than 100% of Federal Poverty Guideline?		
26) **EHS STAFF ONLY:** Family receives TANF/SSI?		
27) **EHS STAFF ONLY**: Is income equal or less than 100% of poverty level?		
TOTAL POINTS		

Parent Signature _____ Date: _____