Head Start/Early Head Start is required to use the Department of Health and Human Services HHS Poverty Guidelines to determine income eligibility.

**HOW DO I APPLY?**

- Complete an application along with copies of Parent(s)/Guardian(s) Income.
- After application is received, an application interview will be scheduled and application will be completed.
- Completing the application process does not guarantee enrollment.
- Applicants are accepted based upon income (Federal Poverty Level) and prioritized using approved selection criteria.
- Upon enrollment to the program, applicants will receive an “Acceptance” letter.

**Please Note:**

1. Enrollment is limited, so please complete your application & enrollment appointment immediately for early consideration.
2. An incomplete application, including no documentation, will delay the enrollment process. Selection for fall enrollment openings will be released July 15th of each year.
# Early Head Start

## Pregnant Women/Expectant Families Application-Intake

**Date of Application-Intake:** ___________________

<table>
<thead>
<tr>
<th>Pregnant Woman Name: __________________________</th>
<th>Date of Birth: <strong><strong>/_____/</strong></strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: __________________________________________________________________</td>
<td>______________</td>
</tr>
<tr>
<td>Street</td>
<td>City</td>
</tr>
<tr>
<td>Phone: (___<strong>) <em><strong><strong><strong>-</strong></strong></strong></em></strong></td>
<td>Message Phone: (___<strong>) <em><strong><strong><strong>-</strong></strong></strong></em></strong></td>
</tr>
</tbody>
</table>

**Hispanic:** Yes [ ] No [ ]

**Race (check all that apply):**
- [ ] Asian
- [ ] White
- [ ] Native American/Alaskan Native
- [ ] Multi-Racial
- [ ] Black/African American

**Highest Grade/Education Completed:**
- [ ] GED/HSED
- [ ] HS Graduate
- [ ] < Grade 9
- [ ] Grade 10
- [ ] Grade 11

**Employment & Training Status:**
- [ ] Full Time
- [ ] Unemployed
- [ ] Part Time
- [ ] Seasonally Employed
- [ ] Full Time & Trng.
- [ ] Part Time & Trng.
- [ ] Retired or Disabled

**Member of U.S. Military Active Duty?**
- [ ] Yes
- [ ] No

**Veteran of the U.S. Military?**
- [ ] Yes
- [ ] No

**Family Receives:**
- [ ] Food Share/SNAP
- [ ] WIC
- [ ] Wisconsin Shares (child care)
- [ ] TANF
- [ ] General Assistance

**Spouse or Partner Name:** ____________________________________________ | Date of Birth: ____/_____/____ |
| Phone: (_____) _______-_________ | Tribal Affiliation: ____________________ |
| Lives with Applicant [ ] | Provides Financial Support [ ] |

**Hispanic:** Yes [ ] No [ ]

**Race (check all that apply):**
- [ ] Asian
- [ ] White
- [ ] Native American/Alaskan Native
- [ ] Multi-Racial
- [ ] Black/African American

**Highest Grade/Education Completed:**
- [ ] GED/HSED
- [ ] HS Graduate
- [ ] < Grade 9
- [ ] Grade 10
- [ ] Grade 11

**Employment Status:**
- [ ] Full Time
- [ ] Unemployed
- [ ] Part Time
- [ ] Seasonally Employed
- [ ] Full Time & Trng.
- [ ] Part Time & Trng.
- [ ] Retired or Disabled
- [ ] Training or School

**Member of U.S. Military Active Duty?**
- [ ] Yes
- [ ] No

**Veteran of the U.S. Military?**
- [ ] Yes
- [ ] No

**OTHER FAMILY MEMBERS FINANCIALLY SUPPORTED BY PRIMARY/SECONDARY ADULT (LIVING IN THE HOME)**

<table>
<thead>
<tr>
<th>First &amp; Last Name</th>
<th>D.O.B.</th>
<th>Relationship to applicant</th>
<th>Total # of Children:</th>
<th>Total # Adults:</th>
<th>Total # in household:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Red Cliff Early Childhood Center  
88455 Pike Rd (mail)  
89830 Tiny Tot Drive (physical)  
Bayfield, WI 54814  
(715) 779-5030  
(715) 779-5046 fax  
www.redcliffec.org
**PARENT(S)/GUARDIAN(S) INCOME STATUS** (Before Taxes)

The following information is required to process this application:
- **Income Verification:** Tax Form or W-2's; Pay Stubs;
- **Public Assistance:** TANF-W-2; and/or SSI-Disability Payments
- **Other:** child support payments, etc.

<table>
<thead>
<tr>
<th>Applicant</th>
<th>Spouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer</td>
<td>Employer</td>
</tr>
<tr>
<td>Since</td>
<td>Since</td>
</tr>
<tr>
<td>☐ Full Time</td>
<td>☐ Full Time</td>
</tr>
<tr>
<td>☐ Part-Time (less than 30 hrs./week)</td>
<td>☐ Part-Time (less than 30 hrs./week)</td>
</tr>
<tr>
<td>Gross Income</td>
<td>Gross Income</td>
</tr>
<tr>
<td>$_________________</td>
<td>$______________</td>
</tr>
<tr>
<td>Paid:</td>
<td>Paid:</td>
</tr>
<tr>
<td>☐ Weekly</td>
<td>☐ Weekly</td>
</tr>
<tr>
<td>☐ Bi-Wkly</td>
<td>☐ Bi-Wkly</td>
</tr>
<tr>
<td>☐ Monthly</td>
<td>☐ Monthly</td>
</tr>
<tr>
<td>W-2 or Tax Return</td>
<td>W-2 or Tax Return</td>
</tr>
<tr>
<td>$_________________</td>
<td>$______________</td>
</tr>
</tbody>
</table>

**OTHER INCOME & CASH ASSISTANCE** (Documents & Verification Required)

<table>
<thead>
<tr>
<th>Social Security Benefits (monthly)</th>
<th>SSI (monthly)</th>
<th>TANF/W-2 (monthly)</th>
<th>Child Support (monthly)</th>
<th>Foster/Kinship Care (monthly)</th>
<th>Unemployment (weekly)</th>
<th>Other Income (List)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

**Family of:** ___________ **Total Income:** ____________

**Family Circumstances** (Please check all that apply to you or your immediate family)

- ☐ Child Protection Services
- ☐ Foster Care/Kinship Care
- ☐ Death of immediate family member
- ☐ Incarcerated Parent
- ☐ Lack of Prenatal Care
- ☐ High Risk Pregnancy
- ☐ Teen Parent
- ☐ Prenatal Substance Use with current pregnancy
  - ☐ Drugs ☐ Alcohol ☐ Tobacco
- ☐ Financially affected by COVID (job/day care loss)
- ☐ Disabled Parent
- ☐ Multiple Births (twins, triplets, etc.)
- ☐ Domestic Violence
- ☐ Single Parent
- ☐ Lack of stable Housing or Homelessness
- ☐ First Time Parent
- ☐ Mental Health Concerns (Depression, Anxiety, etc.)
  - ☐ Concern ☐ Diagnosed (Please explain)

Any other concerns you would like us to know about:

________________________________________________________________________________________________

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**Please Read Before Signing**

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT ALL INCOME IS REPORTED. I UNDERSTAND THAT THE INFORMATION IN THIS APPLICATION WILL BE HELD IN STRICT CONFIDENCE WITHIN THE PROGRAM. I ALSO UNDERSTAND THAT THIS INFORMATION IS BEING GIVEN TO DETERMINE ELIGIBILITY FOR A FEDERAL PROGRAM AND WILL BE VERIFIED FOR ACCURACY.

Signature: ___________________________ Date: ________________

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**This Section for Agency Use Only**

Type of Eligibility: ☐ Income below 100% Poverty Line ☐ 100-130% Above Poverty Line ☐ Public Assistance ☐ Homeless
- ☐ Foster Care (applicant)

Accepted Date: ___________ Wait list Date: ___________ Wait list Home Visitor: ___________
Pregnancy/Health Information

Do you have regular Prenatal Health Care: □ No  □ Yes

Primary Health Coverage/Insurance: □ Badgercare/Medicaid □ Private Health Insurance □ IHS □ None

Last DENTAL exam: ___________________________ Clinic/Provider: __________________

Prenatal Care Physician (OB-GYN): __________________________

Date of first Prenatal Care Visit: __________________________

When did you begin receiving prenatal care: □ 1st Trimester □ 2nd Trimester □ 3rd Trimester

Due Date: ___________________________ (Pregnancy Verification Required)

Is this a high-risk pregnancy: □ Yes □ No

Is this your first pregnancy? □ Yes □ No

Complications

<table>
<thead>
<tr>
<th>Current</th>
<th>Past</th>
<th>Current bed rest or Hospitalization due to ___________ How long__________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Bleeding</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>C-Section</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Diabetes</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Fatigue</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Headache</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Hypertension</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Miscarriage</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Neonatal Death</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Pain</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Pre-Term Labor</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Induced hypertension</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Sickle Cell</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Swelling</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Do you have any other current health problems or concerns? □ No  □ Yes __________________________

Are you currently enrolled in Zaagichigaazowin Home Visiting Program?

□ Yes       □ No

Do you authorize ECC to share your name and contact number with Zaagichigaazowin Home Visiting Program?

□ Yes       □ No