Please fill out the front and back page of the application in black or blue ink, and please PRINT CLEARLY. Sign and date the application and attach proof of all income.

Applications also available at www.familiesfirstmn.org.

Email, Mail or Bring Application and Proof of Income to: Families First of Minnesota Head Start/School Readiness, 126 Woodlake DR SE, Rochester, MN 55904. Email to: anitah@familiesfirstmn.org.

Please keep this page for your reference.

Income qualifying children and families with the greatest need have the highest priority for enrollment. Head Start will do its best to enroll your child, but space is limited.

IMPORTANT: We will contact every family who applies for Head Start. Please tell us if your phone number or address changes.

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Early Head Start is:

- For infants and toddlers up to age 3 who are enrolled in participating childcare centers
- If accepted, this program will be no additional cost to your family
- Early Head Start is an all year program
- Monthly parent groups
- Services provided for children with special needs

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If you need help in other languages or have any questions, call us at:

507-287-2009 Or Toll Free call 1-800-462-1660
RIGHT TO KEEP INFORMATION ABOUT YOU PRIVATE (DATA PRIVACY)

Most of the information we collect about you will be classified as private. That means you and the agency collecting the data can see it; others cannot. Occasionally, statistics and other anonymous data will be taken from the information we collect about you or your family. This is public and open to anyone, but it will not identify you in any way.

In a few cases, information we collect is classified confidential. Confidential data is not open to anyone (not even you) except the government agencies that need it. Data in this category deals with civil or criminal investigation, some medical data, and the names of persons who report child or vulnerable adult abuse.

Purpose of Information

The information you are asked to provide will be used to determine program eligibility, to coordinate services between programs, to verify program services being provided, and to provide us with a mailing list. This list will be used to update you on upcoming programs and program changes and to inform you of eligibility for programs within Families First of Minnesota. Only Head Start or School Readiness Families First staff and funding source employees whose jobs require access to this information, as well as Federal or State Auditors, may have access to your information.

RIGHT TO ACCESS YOUR RECORDS

Access by you. You can see all public and private records about yourself and your children. To see your file, call Families First of Minnesota during agency hours and make a request to review your files within five working days by contacting the program from which you are receiving service. Review will take place on site during working hours.

Access by agency. Employees of this agency will have access to information about you any time their work requires it. By law, some other government and contractor agencies will also have access to certain information about you if they provide a service to you or if they provide a service to this agency that affects you and requires access to your records. They may include school districts, public health, social services and financial assistance.
### Home Address for Family

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Parent/Guardian 1 Phone Number</th>
<th>Parent/Guardian 2 Phone Number</th>
</tr>
</thead>
</table>

### Name of Person if we cannot contact you: ______________________

### Your Email Address (please print clearly):

### Phone Number: ______________________

### Do you speak English? ☐ Yes ☐ No

### Language spoken at home: __________

### Do you need an interpreter? ☐ Yes ☐ No

### Is your family expecting a baby? ☐ Yes ☐ No

#### If yes, due date: ____________________

### Number of People living in your Home ______

### Number of People in your Family ______

### Marital Status (choose one):

- Married
- Married but living apart
- Divorced
- Widowed
- Single Living with Partner
- Single

### Enter code for RACE:

- NA/AN = American Indian / Alaska Native
- A = Asian
- B = Black or African American
- NH/PI = Native Hawaiian / Other Pacific Islander
- W = White
- M = Multi-racial

### Type of medical insurance for each applicant:

- Blue Plus
- Ucare
- None
- Other __________

### Parent/Guardian 1 - Employment status: (Check all that apply)

- Full Time
- Part Time
- Seasonal/On-Call
- Retired/Disabled
- Training or School
- Military

#### Name of employer(s) ____________________

#### Date Started: __________

### Parent/Guardian 2 - Employment status: (Check all that apply)

- Full Time
- Part Time
- Seasonal/On-Call
- Retired/Disabled
- Training or School
- Military

#### Name of employer(s) ____________________

#### Date Started: __________

### Parent/Guardian 1 - Highest level of Education:

- High School Diploma/GED
- Associates
- Bachelors
- No Education
- Completed Grade ______
- Masters or higher

### Parent/Guardian 2 - Highest level of Education:

- High School Diploma/GED
- Associates
- Bachelors
- No Education
- Completed Grade ______
- Masters or higher

### Fill out all information for EACH person living in your home. Please print clearly.

**EHS** = Early Head Start (for infants and toddlers under age 3 who are enrolled in participating childcare centers)

<table>
<thead>
<tr>
<th>FIRST NAME</th>
<th>LAST NAME</th>
<th>BIRTH DATE</th>
<th>SEX</th>
<th>RACE (use code below)</th>
<th>ETHNICITY (Circle ONE)</th>
<th>RELATIONSHIP TO APPLICANT(S)</th>
<th>Applicants only—circle program applying for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian 1 from above (if living in home)</td>
<td>/ /</td>
<td>M F</td>
<td></td>
<td>Hispanic</td>
<td>Non Hispanic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent/Guardian 2 from above (if living in home)</td>
<td>/ /</td>
<td>M F</td>
<td></td>
<td>Hispanic</td>
<td>Non Hispanic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>/ /</td>
<td>M F</td>
<td></td>
<td>Hispanic</td>
<td>Non Hispanic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>/ /</td>
<td>M F</td>
<td></td>
<td>Hispanic</td>
<td>Non Hispanic</td>
<td></td>
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<tr>
<td>5.</td>
<td>/ /</td>
<td>M F</td>
<td></td>
<td>Hispanic</td>
<td>Non Hispanic</td>
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<td>M F</td>
<td></td>
<td>Hispanic</td>
<td>Non Hispanic</td>
<td></td>
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### Enter code for RACE:

NA/AN = American Indian / Alaska Native
A = Asian
B = Black or African American
NH/PI = Native Hawaiian / Other Pacific Islander
W = White
M = Multi-racial

Rev. 1.7.2022 (continued on back)
Please check below All items affecting your family. This helps us to understand your family’s needs and priority for enrollment. Please explain items you check.

<table>
<thead>
<tr>
<th>Item</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster child or child in custody of a relative</td>
<td>Family member(s) with no health insurance</td>
</tr>
<tr>
<td>Child with a special need, IFSP or IEP (child name)</td>
<td>Abuse of alcohol or drugs by either parent</td>
</tr>
<tr>
<td>Child separated from parent due to jail/prison, military deployment or deportation</td>
<td>Refugee status in last five years</td>
</tr>
<tr>
<td>Death of a child’s parent or sibling</td>
<td>Family member with a mental health concern</td>
</tr>
<tr>
<td>Family violence or domestic abuse or order of protection</td>
<td>Moved many times</td>
</tr>
<tr>
<td>Serious medical condition or disability of child’s parent or sibling</td>
<td>Other difficulties causing great stress (please explain):</td>
</tr>
<tr>
<td>Child Protection Involvement</td>
<td></td>
</tr>
<tr>
<td>Significant decrease in family income within last 12 months</td>
<td>NONE of these items are affecting my family</td>
</tr>
</tbody>
</table>

2021 INCOME IS REQUIRED WITH YOUR APPLICATION TO DETERMINE ELIGIBILITY. QUESTIONS ON INCOME CALL: 507-287-2009

Check any of the following your family received within the last 6 months:

- MFIP (CASH Assistance)
- SNAP (Food Benefits)
- WIC
- Cash Assistance from another state
- Child Care Assistance
- SSI (Supplemental Security Income)
- DWP (Diversionary Work Program)
- Refugee Match Grant

From what County? ______________________________________________________

Total monthly income before taxes: $ __________________________

Does anyone in your family receive child support? □ Yes □ No

If Yes, what county? __________________________

Has anyone filed for child support? □ Yes □ No

If Yes, what County? __________________________

Who has custody of the child applicant(s)? ______________________________

Has anyone received Financial Aid Grants or any Scholarships in the last year?

□ Yes □ No

Has anyone received payments from Unemployment, Workers Comp, or Social Security in the last year? □ Yes □ No

What is your current living situation? (check ONE)

- Own, Rent or Share housing by choice
- Living in a hotel, motel, campground, car, etc.
- Sharing housing due to loss of housing or economic hardship
- Home in foreclosure or getting evicted. Eviction date: __________
- Staying at a shelter or Transitional Housing
- Other (please explain) ____________________________________________

Name of childcare center that your child attends: __________________________

What days of the week does your child attend? □ Monday □ Tuesday □ Wednesday □ Thursday □ Friday

Hours that your child attends childcare: __________________________________

Who referred you to our programs? (check All that apply)

- Adult Basic Education or other Adult Literacy Program
- Early Childhood Special Education
- Social or Human Service Agency
- Child Care Program
- Rice County Public Health
- Friends or Family
- Early Childhood Screening
- Health Care Provider
- Other (please specify) _____________________________________________

For the Early Head Start Partnership – I am giving permission to exchange my child/family information which may include health, school, work, attendance, parent share, developmental and enrollment information with the early childhood program my child may or currently attends.

I give permission to Families First of Minnesota Head Start to verify my income and any materials related to my eligibility or enrollment. This includes authorization to verify any public assistance or child support that I may receive from the county I’m working with. To the best of my knowledge the information I have given is accurate and true.

Parent/Guardian Signature __________________________ Print Name: __________________________ Date: __________________________

Did someone help you fill out this application? □ No □ Yes – If yes, Name of person helping you: __________________________

Phone # (______)________ - ____________ May we contact this person regarding your application? □ Yes □ No