Venice Family Clinic

Children First Early Head Start Program Application

Date: _____

Primary adult name: _____ **Date of Birth:** _____

Parents in Household: ☐ Two parents ☐ Single parent ☐ Foster Parent

☐ Other (Relative/Guardian) _____

Program option you are applying for: ☐ Pre-natal ☐ Home-Based ☐ Family Childcare

If applying for Family Childcare, are you? ☐ Employed ☐ In school ☐ Other:_____

Please check all that apply: ☐ Teen Parent ☐ First Time Parent ☐ "High Risk" Pregnancy

Are you currently pregnant? ☐ Yes ☐ No **Baby's Due Date:** _____/_____/_____

Child's Name: _____ **Gender:** ☐ **Male** ☐ **Female**

Child's Date of Birth: _____/_____/_____

Address: _____
Street **City** **Zip Code**

Best phone # to reach you: _____ (circle one: home/cell/work)

Other phone #: _____ (circle one: home/cell/work)

Can we text you? (circle one: yes / no) **E-Mail Address:** _____

In case your family moves during the application process, please list another person who would know how to contact you:

Name/Relationship: _____/_____ Phone: _____

Total number of people living in the house where you live: _____

Total number of children in your family: _____

Language(s) you speak: English_____ Spanish_____ Zapotec_____ Other:_____

How did you hear about the Children First EHS Program? _____

Do you already have a child enrolled in our program? If yes, child's name: _____

Does your child have a developmental delay? ☐ Yes ☐ No

If yes, is the delay diagnosed or suspected? (Please circle one.)

Does your child have an IFSP with Westside Regional Center? ☐ Yes ☐ No
Please explain: _____

If no, are you concerned about your child's health or development? ☐ Yes ☐ No

Please explain: _____

Please check all income and benefits received by your family:

INCOME: TANF/CalWorks_____ SSI_____ Child Support_____ Alimony_____ Unemployment_____

Workers Comp _____ Foster Child/Adoption Subsidy _____ Other Cash Assistance: _____

Grants/Scholarships _____

BENEFITS: WIC_____ Food Stamps_____ MediCal/MediCare_____ Housing Assistance_____

Energy Assistance_____ CHIP_____ State-funded Childcare_____ Other:_____

Please let us know any other issues or concerns you would like to share. (For example: your own health or mental health concerns, homelessness, domestic violence, drug use, depression, etc.)
You may attach another page if you would like:

Please remember: In order to process your application, we need proof of your child's birth and your family's income for the past 12 months.

_____/_____ _____/_____
Parent/Guardian Signature **Date** **Parent/Guardian Signature** **Date**

Confidentiality Statement: *All information shared with the Venice Family Clinic Children First EHS program will be kept strictly confidential, unless written authorization is obtained.*

Non-Discrimination Clause: *U.S. Federal Law prohibits the Venice Family Clinic Children First EHS program from discriminating on the basis of race, sex, age, color, national origin or disabilities in the provision of services and employment.*

Please return your completed application

In person:	By fax:	By mail:
Emma Ramey Children First EHS Venice Family Clinic 2509 Pico Blvd Santa Monica, CA 90405	Attn: Emma Ramey Children First EHS (310) 664-7589	Venice Family Clinic Children First EHS Attn: Emma Ramey 604 Rose Ave Venice, CA 90291

For questions or assistance call Emma at (310) 664-7536