



HEAD START ELIGIBILITY APPLICATION NORTHERN TIER COMMUNITY ACTION CORPORATION

Head Start Program
P.O. Box 389
Emporium PA 15834
Administrative Office: Toll Free: 888-809-3704, Ext. 224
Fax: 814-486-0519

Thank you for your interest in the Northern Tier Community Action Corporation Head Start Program. Along with the attached Eligibility Application, we will need a copy of the items listed below to determine your child's eligibility.

Required Information: You MUST attach to the eligibility application a COPY of your child's:

- Proof of Income
- Immunization Record
- Birth Certificate
- Custody Agreement (if applicable)

Do NOT send original documents

You must attach income documentation (copies only) for all family members contributing to the household income for the past year. Accepted income documentation is:

- Last year's 1040 and W-2 Form(s) for each working person
- Pay Stubs
- TANF Determination Letter
- Social Security/SSI/SSDI Determination Letter
- Child Support
- Unemployment Determination Letter
- Foster Care Other _____

If you need any help completing the application, please call.

Upon completion of this application, please call the number listed for your area to obtain instructions on submitting the application. If no answer, please leave a message.

Bradford 368-9150
Coudersport 274-7017
Emporium 486-4000, Ext. 2077
Johnsonburg 965-3389 or 965-5627
St. Marys 781-7776 or 781-6666

Eldred 225-2200 or 225-4018
Port Allegany 642-2807
Ridgway 772-4030
Kane 389-5720

We will notify you by letter after we have received all of the above requested information and your child's eligibility has been determined. Failure to submit all requested information will delay the eligibility determination.

When your child is determined eligible, enrollment into the program will be based upon availability and guidelines for selection. We look forward to providing a Head Start experience for your family!



Northern Tier Community Action Corporation
HEAD START PROGRAM

2020 INCOME GUIDELINES

Family Size	100% Annual Income	130%
1	12,760	16,588
2	17,240	22,412
3	21,720	28,236
4	26,200	34,060
5	30,680	39,884
6	35,160	45,708
7	39,640	51,532
8	44,120	57,356

For family units with more than 8 members, add \$4,480 for each additional person.

Priority given to income eligible families.
10% of families can be above the income guidelines.



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Head Start Program
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Emporium PA 15834
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Fax: 814-486-0519

Revised: 2/22

CHILD'S INFORMATION

Last Name: _____ First Name: _____ Date of Birth: ____/____/____

Address: (street, city, state, zip code): _____

Rent Own Live with Family/Friends Other _____

Gender: Female Male Hispanic: Yes No Language Spoken In Home: _____

Race: Black or Af. Am. White Multi-Racial/Bi-Racial Asian Am. Indian/Alaskan Native Other _____

Does your child have a special need/disability/health concern? No Yes If yes, please describe and provide documentation: _____

Does your child have a current Individualized Education Plan (IEP)? No Yes Unsure

Is your child receiving services with another agency? No Yes If yes, which agency? _____

Is your child potty-trained? (This will not affect your child's enrollment) No Yes

PRIMARY ADULT INFORMATION

Last Name: _____ First Name: _____ Date of Birth: ____/____/____

Address: (street, city, state, zip code): _____

Phone: Land Line: _____ Cell: _____ Work: _____ Alternate: _____

Gender: Female Male Hispanic: Yes No Primary Language: _____ Marital Status: _____

Race: Black or Af. Am. White Multi-Racial/Bi-Racial Asian Am. Indian/Alaskan Native Other _____

Child's Relationship: Biological Adopted Step Foster Grandchild Other _____ Legal Custody: Yes No

Highest Level of Education: Less than a High School Graduate High School Graduate GED
 Some College/Vocational or Advanced Training Associate Degree Bachelor's Degree Master's Degree

Employment Status: Employed Not Employed Currently Enrolled: Job Training Secondary Education

Teen Parent (at time of child's birth under age 18) Yes No EMAIL (Required): _____

SECONDARY ADULT INFORMATION

Last Name: _____ First Name: _____ Date of Birth: ____/____/____

Address: (street, city, state, zip code): _____

Phone: Land Line: _____ Cell: _____ Work: _____ Alternate: _____

Gender: Female Male Hispanic: Yes No Primary Language: _____ Marital Status: _____

Race: Black or Af. Am. White Multi-Racial/Bi-Racial Asian Am. Indian/Alaskan Native Other _____

Child's Relationship: Biological Adopted Step Foster Grandchild Other _____ Legal Custody: Yes No

Highest Level of Education: Less than a High School Graduate High School Graduate GED
 Some College/Vocational or Advanced Training Associate Degree Bachelor's Degree Master's Degree

Employment Status: Employed Not Employed Currently Enrolled: Job Training Secondary Education

Teen Parent (at time of child's birth under age 18) Yes No EMAIL: _____

FAMILY INFORMATION

OTHER ADULTS (NOT the Primary and Secondary) living in the household (Attach separate sheet of paper if necessary):

Last Name	First Name	Date of Birth	Sex	Race	Hispanic? Yes or No	Relationship to Child	Highest Level of Education	Employment Status

OTHER CHILDREN (NOT the Applicant living in the household (Attach separate sheet of paper if necessary):

Last Name	First Name	Date of Birth	Sex	Race	Hispanic? Yes or No	This Child's Relationship to the Child Applicant

Number In Household: _____ **Number in Family:** _____ **Household Status:** Single Parent Two-Parent

Parent currently incarcerated: Yes No
 Homeless Family: Yes No
 Receiving SNAP: Yes No
Receiving WIC: Yes No
 Referred by Child Welfare Agency or Mental Health Provider: Yes No
Receiving TANF(Cash Assistance): Yes No
 SSI: Yes No
 Do You Receive Child Support? Yes No
Active Military Yes No
 Military Veteran Yes No

FAMILY INCOME

YOU MUST ATTACH PROOF OF INCOME TO THIS APPLICATION. Proof of income include Tax Form 1040 & W-2, determination letters for TANF, SSI, unemployment and child support, foster care subsidy, paystubs and a letter from the employer on official letterhead. **Head Start staff will be completing an Eligibility Verification Form listing the actual income amount(s) obtained from the proof of income you provide. We require you to fill out the Source, Person Receiving, and Payment Frequency in the chart:**

Source of Income	Person Receiving	Payment Frequency	Proof Attached
Employment Primary Adult	_____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 wks <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employment Secondary Adult	_____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 wks <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	<input type="checkbox"/> Yes <input type="checkbox"/> No
Public Assistance: <input type="checkbox"/> TANF (Cash Assistance Only)	_____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 wks <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> SSI	_____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 wks <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> SNAP	_____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 wks <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unemployment	_____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 wks <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	<input type="checkbox"/> Yes <input type="checkbox"/> No
Foster Care/Adoption Subsidy	_____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 wks <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child Support (Only the child applicant)	_____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 wks <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other- Specify: _____	_____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 wks <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	<input type="checkbox"/> Yes <input type="checkbox"/> No
Zero Income	N/A	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No

PROGRAM OPTIONS

Center: Operates from September through May. Centers are located in Bradford, Coudersport, Emporium, Johnsonburg, Kane, Eldred, Port Allegany, Ridgway, and St. Marys.

Home Base: Operates from August through May. The Home Base option provides families with 1 1/2 hours of home instruction weekly and two socializations monthly with other home based children.

If both options are available in your area, please check which option you prefer:

- Center Only - If classroom is full, will remain on waiting list in case of opening at the center
- Center with Home Base as an option if classroom is full
- Home Base option only
- St. Marys only -3 day center option (part day-3 hours)

OTHER INFORMATION

Is there any additional information you wish to provide such as suspected disability, major medical concerns, hardships, homeless status, etc.?

I have attached the following required information and signed /dated and reviewed the application to verify that all areas are fully completed. I understand if the following documentation is not attached, it will delay my child's application process.

- Copy of child's immunization record
- Copy of child's birth certificate
- Copy of current income
- Copy of custody agreement (if applicable)

Certification: I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. If any information changes, I am obligated to notify the program immediately. I also understand that the information in this application will be held in strict confidence and is used to determine eligibility but does not guarantee enrollment into the program. Northern Tier Community Action Corporation does not discriminate on the basis of sex, age, religion, national origin or disabilities.

Parent/Guardian Signature _____ **Application Date:** _____

Head Start Staff Signature _____ **Date Staff Received:** _____

PLEASE FILL OUT THE SECTION BELOW ONLY IF YOUR CHILD HAS A CURRENT IEP

IEP/ER Release of Information

I give my permission for Northern Tier Community Action Corporation Head Start Program to obtain a copy of the most recent IEP/ER from Seneca Highlands Intermediate Unit Nine for my child, _____.
(Print Child's Name)

I understand this information is being requested for the purpose of program enrollment and provision of service. In order to protect the confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the agency listed above, and will be effective for one year from the date signed below. I understand that I may withdraw my permission at any time. I also understand that upon request I will receive a copy of the information.

Signature of Parent/Guardian

Town/City

Date