LSU Health NEW ORLEANS
School of Allied Health Professions
Human Development Center

Early Head Start Child Care Partnership

Thank you for your interest in the LSUHSC Early Head Start Child Care Partnership Program. We are a federally funded program that works with families of children ages birth to three (3) years old. If you believe that you may qualify to participate in our program, please complete one of our applications and provide the following documentation:

For the child:

- Birth certificate (or live birth letter if under 2 months)
- Immunization records (must be up to date)
- Health Insurance or Medicaid card
- WIC Voucher (if applicable)
- Proof of Guardianship (if applicable)
- Early Steps Individualized Family Services Plan (IFSP) (if applicable)

For the parent/family:

- Copy of photo ID
- Proof of income (provide one of the following)
  - Four(4) most recent check stubs
  - Letter from employer (hourly wage, average hours per week)
  - Tax return (if self-employed)
- Child Care Assistance Program (CCAP) documentation

  If you have not yet applied for CCAP, you can do so at http://www.louisianabelieves.com/early-childhood/child-care-assistance-program
- SSI documentation (if applicable)
- FITAP or TANF documentation (if applicable)
- SNAP documentation (if applicable)

All documentation can be submitted via fax (504-556-7501) or email (EarlyHeadStart@lsuhsc.edu). If you have any questions, please contact Raynell Washington, ERSEA Specialist, at 504-556-7537.

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APPLICATION/INTERVIEW FORM

PLEASE COMPLETE THE FOLLOWING TO THE BEST OF YOUR KNOWLEDGE.
THIS IS A CONFIDENTIAL DOCUMENT AND CANNOT BE SHARED WITHOUT CONSENT OF THE APPLICANT.

CHILD'S NAME: _____D.O.B: _____RACE: _____HISPANIC:___ YES___NO

SEX: _____MALE _____FEMALE

ZIP:_____

ADDRESS: _____

HOME PHONE #: _____OTHER PHONE #: _____EMAIL: _____

OPT IN FOR TEXT MESSAGES/EMAILS: ___YES___ NO

IS ENGLISH PRIMARILY SPOKEN IN HOME? Y / N

DO YOU SPEAK A LANGUAGE OTHER THAN ENGLISH? Y / N IF YES, WHICH LANGUAGE? _____

PLEASE CHOOSE THE PARENTAL STATUS THAT BEST DESCRIBES YOUR RELATIONSHIP TO THE CHILD:
☐ SINGLE PARENT ☐ TWO PARENT ☐ GRANDPARENT ☐ LEGAL GUARDIAN/ADOPTED ☐ FOSTER PARENT

FAMILY INFORMATION (PARENTS OR LEGAL GUARDIAN): IF SOMEONE OTHER THAN THE PARENT APPLIES FOR THE CHILD, DOCUMENTATION INDICATING THAT THE PERSON IS THE CHILD'S LEGAL GUARDIAN MUST BE SUBMITTED.
PLEASE ANSWER ALL KNOWN INFORMATION ABOUT BOTH PARENTS.

MOTHER/LEGAL GUARDIAN: _____
D.O.B.: _____ RACE: _____
LIVES WITH CHILD? Y / N HISPANIC? Y / N

ADDRESS: _____
ZIP: _____ PHONE#: _____

HIGHEST GRADE COMPLETED? **(CHECK ONE ONLY)**

☐ < GRADE 9	☐ COL DEG/TRAIN
☐ GRADE 10	☐ COL OR ADV TRAIN
☐ GRADE 11	☐ ASSOCIATE'S
☐ GRADE 12	☐ BACHELOR'S
☐ HS GRADUATE	☐ MASTER'S
☐ GED	

OCCUPATION: _____ANNUAL INCOME: _____
NAME OF EMPLOYER: _____

EMPLOYMENT STATUS: **(CHECK ONE ONLY)**

☐ FULL TIME	☐ FULL TIME & TRAINING
☐ PART TIME	☐ PART TIME & TRAINING
☐ SEASONAL	☐ TRAINING OR SCHOOL
☐ UNEMPLOYED	☐ RETIRED OR DISABLED

ARE YOU CURRENTLY IN SCHOOL/TRAINING PROGRAM? Y / N
NAME OF SCHOOL ATTENDING: _____

FATHER/LEGAL GUARDIAN: _____
D.O.B.: _____ RACE: _____
LIVES WITH CHILD? Y / N HISPANIC? Y / N

ADDRESS: _____
ZIP: _____ PHONE#: _____

HIGHEST GRADE COMPLETED? **(CHECK ONE ONLY)**

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OCCUPATION: _____ANNUAL INCOME: _____
NAME OF EMPLOYER: _____

EMPLOYMENT STATUS: **(CHECK ONE ONLY)**

☐ FULL TIME	☐ FULL TIME & TRAINING
☐ PART TIME	☐ PART TIME & TRAINING
☐ SEASONAL	☐ TRAINING OR SCHOOL
☐ UNEMPLOYED	☐ RETIRED OR DISABLED

ARE YOU CURRENTLY IN SCHOOL/TRAINING PROGRAM? Y / N
NAME OF SCHOOL ATTENDING: _____

IS EITHER PARENT/LEGAL GUARDIAN AN ACTIVE MEMBER OF THE MILITARY? ___ YES___NO

IS EITHER PARENT/LEGAL GUARDIAN A VETERAN? ___ YES___NO

IS EITHER PARENT INCARCERATED? ___ YES___NO

DOES EITHER PARENT HAVE AN IDENTIFIED DISABILITY? ___ YES___NO

WERE YOU REFERRED TO OUR PROGRAM BY A CHILD WELFARE AGENCY? ___ YES___NO

DO YOU HAVE A PERMANENT ADDRESS? ___ YES___NO

DOES YOUR FAMILY RECEIVED ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

□ SSI □ TANF □ FITAP □ SNAP □ WIC (PLEASE PROVIDE WIC ID) _____

DO YOU CURRENTLY RECEIVED CHILD CARE ASSISTANCE/CHILD CARE SUBSIDY? ___ YES___NO

HAVE YOU BEEN PLACED ON THE WAITLIST FOR THE CHILD CARE ASSISTANCE PROGRAM? ___ YES___NO

DO YOU WORK OR ATTEND SCHOOL FOR 20 OR MORE HOURS A WEEK BUT NOT RECEIVING CCAP? ___ YES___NO

HAS YOUR CHILD EVER ATTENDED A DAYCARE? ___ YES___NO

IF YES, WHERE? _____

PLEASE LIST OTHER PERSONS IN YOUR HOUSEHOLD. (USE THE BACK OF SHEET IF MORE SPACE IS NEEDED)

NAME OF MEMBERS	DOB	RELATIONSHIP TO CHILD	OCCUPATION (STUDENT/SCHOOL)	DISABILITY (Y/N)

EMERGENCY CONTACTS

NAME	RELATIONSHIP TO CHILD	CONTACT NUMBER

HEALTH INFORMATION AND ASSESSMENT

DOES YOUR CHILD CURRENTLY RECEIVE SERVICES THROUGH EARLY STEPS? ___ YES___NO
(IF YES, PLEASE PROVIDE INDIVIDUAL FAMILY SERVICE PLAN ALSO KNOWN AS AN IFSP)

DOES YOUR CHILD HAVE ANY OTHER SPECIAL HEALTH NEEDS? ___ YES___NO

IF YES, PLEASE EXPLAIN: _____

WAS YOUR CHILD BORN PREMATURELY? ___ YES___NO IF SO, AT HOW MANY WEEKS WAS THE CHILD BORN? _____ WEEKS

DID YOUR CHILD REMAIN IN NICU AFTER BIRTH? ___ YES___NO IF SO, FOR HOW LONG? _____

DOES YOUR CHILD RECEIVE TREATMENT FOR: **(CHECK ALL THAT APPLY)**
□ ANEMIA □ ASTHMA □ HEARING DIFFICULTIES □ VISION PROBLEMS □ HIGH LEAD LEVEL
□ DIABETES □ ALLERGIES (PLEASE LIST) _____

DOES YOUR CHILD HAVE ANY FOOD ALLERGIES OR DIETARY RESTRICTIONS? ___ YES___NO

IF YES, PLEASE EXPLAIN: _____

HEALTH INSURANCE: _____INSURANCE/MEDICAID NUMBER: _____

DOCTOR'S NAME: _____ LOCATION: _____ PHONE: _____

DATE OF LAST CHILD'S LAST HEALTH CHECKUP: _____

DENTIST'S NAME: _____ LOCATION: _____ PHONE: _____

DATE OF LAST CHILD'S LAST DENTAL EXAM: _____

I CERTIFY THAT THE ABOVE IS TRUTHFUL TO THE BEST OF MY KNOWLEDGE.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

VERIFIED BY LSUHSC EHS STAFF:

SIGNATURE OF STAFF: _____ DATE: _____