I CARE, INC - HEAD START PROGRAM 412 Winston Avenue Statesville, NC 28677 Telephone: 704-873-2858 Fax: 704-873-4865	**APPLICATION** **Center:** G Buffalo Shoals G MooresvilleG Southeast

Father/Guardian: ____ D.O.B.: ____/____/______
Language: ___________________ Ethnicity: ________________ Marital Status: ________________
Employer/School: ____________________________ Paid Wkly: ______ Biwkly: ______ Mo: ______
Physical Address: _____________________________City: ______________ State: ____ Zip:_______
Mailing Address: _____________________________City: ______________ State: _____Zip:_______
Phone: Hm: _________________________ Wk:_____________________ Cell:__________________
Relations To Child: _________________ Biological Parent:________________ Other:_____________
Head of Household: _____Y _____N Education Level: _____________________________________

Mother/Guardian: ____ D.O.B.: ____/____/____
Language: ___________________ Ethnicity: _______________ Marital Status: __________________
Employer/School: ____________________________ Paid Wkly: ______ Biwkly: ______ Mo: ______
Physical Address: _____________________________City: ______________ State: ____ Zip:_______
Mailing Address: _____________________________City: ______________ State: _____Zip:_______
Phone: Hm: _________________________ Wk _____________________ Cell:__________________
Relations To Child: ___________________ Biological Parent:_______________ Other:____________
Head of Household: _____Y _____N Education Level: _____________________________________

Child's Name: _______________________________________ M___ F ___: D.O.B.: ____/___/___
Ethnicity: ______________________ Language: ____________________ Special Needs: __________
____
Referred By: ____
Currently being served in a Childcare/Preschool Program: ___Y ___N, If yes where: ______________
____

List all in Household dependent on income:		**Please check all services that your family receives:**			
Name	D.O.B.	Food Stamps		TANF	
		WIC		SSI	
		Child Care		Child Support	
		Medicaid		Medicare	
		Housing Assistance		SS	

Directions to home: ____
____

I hereby certify that the information provided in this application is accurate and truthful to the best of my knowledge. Falsification of information can mean immediate dismissal from the program.

Parent Signature: Date:

OFFICE USE ONLY
GCertify that I have examined the following documents: G Paycheck G W2 Form G Tax Return G Written Statement from Employer GOther: _________________________________
GIncome Verification G Birth Certificate G Shot Record G Medicaid G Insurance Card

Health Coverage: Medicaid # _____________________ Primary Coverage #: _____________________
Insurance #: ______________________________

Staff Signature: ____ Date: ____________________