



# Durham Early Head Start 2011 Application Prenatal



## What is Early Head Start?

Early Head Start is a free, comprehensive child development and family support program for low-income families with children aged birth to three years old and to pregnant women.

**Home-Based Services:** Expecting moms receive home visits at least once per month from a Home Visitor who is trained in the research-based Partners for a Healthy Baby curriculum. Moms receive information and support on having a healthy pregnancy, as well as resource and referral information. Expecting moms also have the opportunity to attend a Play Group with other children and families twice per month. Home visits are available in Spanish and English. Expecting moms and their babies can remain in the Home-Based program option until the child is 3 years old without completing another application.

**Center-Based Services:** Moms may choose to enroll their child in full-day/full year childcare in one of our partnering centers. Early Head Start teachers and staff provide a nurturing and stimulating learning environment for children. Family Service Coordinators meet individually with parents to provide information, resources and support. To enroll a child in the Center-Based program option, parents must provide the child's birth certificate and complete a full Durham Early Head Start Application.

## Who is Eligible for Durham Early Head Start Services?

Pregnant women whose:

- Address in Durham is within the following zip codes: 27701, 27703, 27704, 27705, 27706, 27707, 27712, and 27713
- Income meets eligibility requirements as determined by Federal Poverty Guidelines (as of 01/20/2011):

Family Size	Family's Yearly Income	Family Size	Family's Yearly Income
2	\$19,123	6	\$38,987
3	\$24,089	7	\$43,953
4	\$29,055	8	\$48,919
5	\$34,021	For each additional family member add: \$3,820	

### Prenatal Application Check List:

We cannot determine your eligibility for our program until we receive the following:

- COMPLETED AND SIGNED APPLICATION
- PROOF OF INCOME OR FULL-TIME SCHOOL - Current Month's Pay stubs, most recent W-2, most recent 1040 Tax form, SSI or TANF documentation, Employer's statement, Letter from School, School schedule
- PROOF OF DURHAM RESIDENCY – Copy of any of the following documents with your name and current mailing address - electric, water, gas, phone (not cell) , cable, lease agreement, deed, tax bill

**Please contact us if you need more information or assistance in filling out an application. You can mail or drop off your application and supporting documents to our office. If you bring your information into the office, we will make copies. Our central office is located at:**

**1201 S. Briggs Avenue, Suite 110  
Durham, NC 27703  
919-439-7107**

**Note: Applications and bi-lingual assistance are available in Spanish**

**Durham Early Head Start  
Prenatal Enrollment Application  
For Home-Based Services**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**MOTHER'S LAST NAME**                      **FIRST**                      **MIDDLE**                      **DATE OF BIRTH**

\_\_\_\_\_  
**HOME ADDRESS**                      **CITY/STATE**                      **ZIP CODE**                      **HOME PHONE**

\_\_\_\_\_  
**MAILING ADDRESS (If different from above)**                      **CELL PHONE**

\_\_\_\_\_  
**EMAIL Address -**                      **WORK PHONE**

**Mother's Race (Check one):**     White/Anglo                       Black/African-American                       Native American                       Asian  
 Pacific Islander                       Multi-racial or Other (specify): \_\_\_\_\_

**Mother's Ethnicity (Check one):**     Hispanic                       Not Hispanic

**Do you have any children that are currently enrolled in Early Head Start or Head Start?**     Yes     No

**Do you have any children that were previously enrolled in Early Head Start or Head Start?**     Yes     No

**Your health insurance coverage:**     Medicaid                       Health Choice     None     Other \_\_\_\_\_

**MEDICAL INFORMATION:**

What is your expected Delivery Date?	Who provides your Prenatal Care?
When did you first receive prenatal care?	Provider's address:
When was your last visit?	Is this pregnancy considered high risk?
Mother's Dental Provider:	When was your last dental exam?
Pregnancy Complication – Current or previous: Anemia: _____ Headache: _____ Swelling: _____ Hypertension: _____ Preg. Induced hypertension: _____ Sickle Cell: _____	Diabetes: _____ Fatigue: _____ Bleeding: _____ C-Section : _____ Miscarriage: _____ Pre-term labor: _____ Neonatal Death: _____
Have you received: <input type="checkbox"/> Mental health intervention (including substance abuse prevention & treatment) <input type="checkbox"/> Prenatal Education on fetal development <input type="checkbox"/> Information on breastfeeding	
Current bed rest or Hospitalization due to : _____ How long: _____ Previous bed rest or Hospitalization due to: _____ How long: _____	
Is there any additional information regarding your pregnancy that will be helpful in providing prenatal support services to you? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, explain: _____ _____	

**All information in this application is kept confidential**

**Family Information (continued):**

Will the new baby live with  Both Parents  Father  Mother  Grandparent(s)  Other \_\_\_\_\_

Are you (check one):  Single  Married  Separated  Divorced  Widowed  Living together, not married

List below everyone who lives in the home (Children, Spouses, other family members, and non-relatives, etc):

NAME	Sex	Age	Date of Birth	Relationship to Child

The following questions include issues that are sensitive and private. Your honest answers help us determine your family's needs, as we are directed to do by our Federal Grant. All answers will be kept private and only used for eligibility purposes.

- Yes  No Are you living with a friend, family member, or in a shelter because you cannot afford a place of your own?
- Yes  No Has your family ever been involved with Child Protective Services (CPS)?
- Yes  No Have you or your children witnessed alcohol or drug abuse in your household?  
If yes, please explain: \_\_\_\_\_.
- Yes  No Have you or your children witnessed physical or verbal violence in your community or in your home?
- Yes  No Do you feel that your house and/or neighborhood is unsafe?
- Yes  No Does any family member living within your home have a documented disability or mental illness?  
If yes, who? \_\_\_\_\_.
- Yes  No Is any family member receiving SSI (Supplemental Security Income)?
- Yes  No Have you recently lost a spouse or partner due to death, incarceration, separation, divorce, or abandonment?  
If yes, please explain: \_\_\_\_\_.
- Yes  No Do you feel isolated and/or have little opportunity to interact with others?
- Yes  No Have there been any other serious events which have put stress on your family recently?  
If so, please explain: \_\_\_\_\_  
\_\_\_\_\_

**Are other community agencies providing services to you or anyone else living in your house?**

Yes  No If yes, please list below.

AGENCY	PHONE NUMBER	PERSON'S NAME

**Does your family receive any of the following services or assistance? (Check all that apply):**

- Medicaid/Medicare  Food Stamps  WIC  Housing Assistance  TANF/Public Assistance/Work First

**FAMILY INCOME:**

	Mother	Father (if living in home)	Other Relative's Income
Current Employer			
How long?	____ Years    ____ Months	____ Years    ____ Months	____ Years    ____ Months
Work hours per week?			
Income Amount	\$	\$	\$
Payment Received	<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month	<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month	<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month

**OTHER SOURCES OF INCOME THAT MUST BE INCLUDED (must be documented)**

Child Support (for all children)	Monthly Amount \$
Work First/TANF	Monthly Amount \$
Supplemental Social Security Income (SSI)	Monthly Amount \$
Foster Care Payments	Monthly Amount \$
Social Security Benefits (SSA)	Monthly Amount \$
Work Study, Fellowship or Grant Award	Monthly Amount \$
Unemployment	Monthly Amount \$



**Please tell us how you found out about Durham Early Head Start.**

Flyer, Brochure, Poster   
  Staff Person   
  Word of Mouth   
  Radio/TV/Newspaper   
  Family Friend

Case Worker   
  Doctor's Office (which one?) \_\_\_\_\_   
  Other: \_\_\_\_\_

I certify that the information provided in this application, including income, is accurate and truthful to the best of my knowledge.

\_\_\_\_\_  
Parent/Legal Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Intake Staff Signature (if applicable)

\_\_\_\_\_  
Date