

Marin Head Start Application for Wait List
 359 Bel Marin Keys Blvd, Suite 1 Novato, CA 94949 415-883-3791 Fax 415-883-6088
 child@marinheadstart.org

Child's Name _____ Birth date _____ Gender _____

Primary language spoken _____ other language(s) _____ Race/Ethnicity _____

Does your child have a diagnosed disability or special need? ____ If yes, what is the diagnosis? _____

What provider/ agency are you working with around your child's special needs? _____

Parent/Guardian _____ Birthdate _____ Gender ____ Relationship to child _____

Primary language spoken _____ Other language(s) _____ Race/Ethnicity _____

Lives with child: ____ Yes ____ No if no, please list other address _____

Parent/Guardian _____ Birthdate _____ Gender _____ Relationship to child _____

Primary language spoken _____ Other language(s) _____ Race/Ethnicity _____

Lives with child: ____ Yes ____ No if no, please list other address _____

Address _____ City _____ Zip Code _____

Phone Numbers: Home _____ Work _____ Cell _____

What number do we call first? _____

Child lives with: One parent ____ Two parent's ____ other adult? _____

Number of people in your immediate family? _____ / How many people living in the home? _____

What is your family's total monthly income before taxes? _____

Source of income (✓ all that apply)
 Work ____ TANF ____ Cal Works ____ SSI ____ Other _____

Is your child receiving WIC?
 ____ yes ____ no

List your child's siblings that live in the home.

Name of sibling	Male/Female	Birth date

All of the above information must be filled in and complete or your application will not be processed.

Certification: I certify that this information is true. If any part is false my participation in this agency's program may be terminated. I also understand that the information in this application will be held in strict confidence.

Parent/Guardian Signature: _____ Date: _____