

**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** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **Gender** \_\_\_\_\_  
Month Day Year  
 Primary language spoken \_\_\_\_\_ Other language(s) \_\_\_\_\_ Race/Ethnicity \_\_\_\_\_

Is your child receiving **WIC**?  yes  no

Does your child have a diagnosed disability or special need?  yes  no If yes, what is the diagnosis? \_\_\_\_\_

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

Parent/Guardian #1 \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ 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 #2 \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ 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 \_\_\_\_\_

**Do you consider your family homeless?**  yes  no  
 (Proof will be required)

**Phone Numbers:** Home \_\_\_\_\_ - \_\_\_\_\_ Cell \_\_\_\_\_ - \_\_\_\_\_ Additional Number \_\_\_\_\_ - \_\_\_\_\_

What number do we call first? \_\_\_\_\_ **E-mail:** \_\_\_\_\_

Number of people in your immediate family \_\_\_\_\_ How many people living in the home? \_\_\_\_\_

**Family Income**

Parent/Guardian #1 What is your monthly income before taxes? \$ \_\_\_\_\_  day  week  month  annual  
 Source of income (circle all that apply) \_\_\_\_\_ Work TANF Cal Works SSI Other

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Parent/Guardian #2 What is your monthly income before taxes? \$ \_\_\_\_\_  day  week  month  annual  
 Source of income (circle all that apply) \_\_\_\_\_ Work TANF Cal Works SSI Other

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

Name of sibling	Male/Female	Date of Birth

**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:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_