Marin Head Start
Application for Expectant Women Wait List

359 Bel Marin Keys Blvd, Suite 1 Novato, CA 94949 (415) 883-3791 Fax (415)883-6088
child@marinheadstart.org

Name of Expectant Mother _____ ***Mother's Date of Birth*** _____/_____/_____
Month Day Year

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

Estimated Due Date _____/_____/_____ ***Prenatal/Health Care Provider*** _____ ***Phone*** _____-_____
Month Day Year

Are you receiving **WIC**? ❒ Yes ❒ No
Does your baby have a suspected special need? _____ If yes, what is the diagnosis? _____
What provider/ agency are you working with around your pregnancy? _____

Phone Numbers: Home_____-_____ Cell_____-_____ Additional Number_____-_____

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

Address_____**City**_____**Zip Code**_____

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

Partner's Name_____ Partner's date of birth_____/_____/____ Gender_____

Primary language spoken_____ Other language(s) _____Race/Ethnicity_____

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

Family Income

Adult #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

Adult #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	Birth date

Other information Head Start may need to know… _____

_____

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:*** _____/_____/_____