LHSA
A Community Action Agency

CHILD'S NAME: _____

Year: 1 2 3

EARLY HEAD START / HEAD START
Family Partnership Agreement

To build relationships with families that support family well being, strong relationships between parents and their children and ongoing learning and development for both parents and children.

Our Family Partnership Agreement includes:

- **Family Intake Form**
- **Family Needs Assessments**
- **Family Engagement Goals & Objectives**
- **Baseline Matrix**

Parent Signature: _____ Date: _____

Staff Signature: _____ Date: _____

HEAD OF HOUSEHOLD INFORMATION (Parent/Guardian Information)

NAME: _____ BIRTHDATE:_____ GENDER: (Please circle) M / F
(Last) (First) (Middle)

ADDRESS: _____ APT/LOT: _____ P.O. BOX: _____

CITY: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____

Marital Status (please circle one): Divorced, Legally Separated, Married, Partner, Single, Widow

Languages Spoken:
Is English the primary language spoken in the home? No _____ Yes _____
Is there a second language spoken in the home? No _____ Yes _____
What languages is the child exposed to on a regular basis through home or family?_____

Family Type (please circle one):
Foster Parent, Grandparent, Legal Guardianship, Married-Living with children, Multiple Adults-Living with children, Single Parent-Female, Single Parent-Male

Living Arrangements (please circle one):
Own, Rent-Unsubsidized, Rent-Subsidized, Living with Friends/Family, Transitional/Shelter, Homeless

Education (please circle one):
Grade 9, Grade 10, Grade 11, Grade 12, High School Graduate, High School Graduate & Some Post-Secondary, GED, Training Certification, Advance Training, Associates Degree, Bachelor's Degree, Master's Degree, None

Military:
Is either parent/guardian a member of the U.S. military on active duty? No_____ Yes_____
Is either parent/guardian a veteran of the U.S. military? No_____ Yes_____

Employment Status (please circle one):
Unemployed, Seasonal, Part-Time with Benefits, Part-Time w/o Benefits, Full Time with Benefits, Full-Time w/o Benefits

Employer: _____ Job Description/Title: _____

Do you have health insurance: Medicaid _____ Employer _____ Private_____Other_____

*THE FOLLOWING INFORMATION IS REQUESTED FOR STATISTICAL PURPOSES ONLY. CIRCLE **ONE** FOR EACH CATEGORY:*

Ethnicity: Hispanic or Latino Origin Non-Hispanic/Non-Latino

Race: Native American or Alaskan Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Bi-Racial or Multi-Racial
Other (Please Specify):_____

FAMILY INFORMATION

For the purpose of Head Start enrollment**: FAMILY,** for a child**,** means all persons living in the same household who are:
(1) supported by the child's parent(s) or guardians(s) income **AND**
(2) related to the child's parent(s) or guardian(s) by blood marriage or adoption **OR**
(3) the child's authorized caregiver or legally responsible party

In addition to the Head of Household above, please list family members (including the enrolling child) in the home to be counted towards enrollment as defined above: (Please list adults first)

Name	Sex	DOB	Ethnicity	Race	Primary Language	Education Level	Employment Status (if applicable)	Employer (if applicable)	Relationship to HH	Health Insurance Employment Based/Medicaid/ Medicare/None
1.										
2.										
3.										
4.										
5.										
6.										

 # IN HOUSEHOLD (Head of Household + Those listed above) = _____

ENROLLING CHILD'S INFORMATION

CHILD'S NAME_____
(Last) (First) (Middle)

Child Lives with (Please Circle): Both Parents Mother Father Guardian(s) Other:_____

NON-CUSTODIAL PARENT NAME:_____

ADDRESS: _____ PHONE: _____

Is there a court order that prohibits or restricts this parent's contact with the child? No _____ Yes _____
If yes, please supply a copy of court order to EHS/Head Start staff.

THESE QUESTIONS ARE ASKED SOLELY TO MEET THE EHS/ HEAD START REQUIREMENTS FOR MAKING 10% OF THE ENROLLMENT OPPORTUNITIES AVAILABLE TO CHILDREN WITH DISABILITIES.

Does your child have a diagnosed special need or an IEP/IFSP? No _____ Yes _____

If yes, describe diagnosis: _____

Is your child receiving services currently? No _____ Yes _____ If so, where? _____

ADDITIONAL INFORMATION

Are parent(s)/guardian(s) enrolled in an educational or job training program?

Mother/Guardian: No_____ Yes_____ Where:_____

Father/Guardian: No_____ Yes_____ Where:_____

Is family currently working with any other agencies or programs (i.e. DHHS (WIC, SNAP, MEDICAID), Section 8, Community Mental Health, etc.)?

No_____ Yes_____ List agencies: _____

Please complete our Third Party Consent form so that we may coordinate our efforts in providing services to you and your family.

ELIGIBILITY INFORMATION – *TO BE COMPLETED BY STAFF*

Is this family eligible? ☐ YES ☐ NO Is this child: ☐ Homeless or in ☐ Foster Care

What documentation has been collected to demonstrate family is eligible at time of enrollment? _____

INCOME INFORMATION

Does this family receive public assistance? ☐ YES ☐ NO If so, please check one: ☐ SSI ☐ TANF (Cash Assistance) ☐ SNAP

Families receiving public assistance are automatically income eligible. Income documentation is not collected, however proof of eligibility MUST be provided.

What documentation has been collected to demonstrate family is receiving public assistance at time of enrollment? _____

For all other families, twelve (12) months of income documentation **MUST** be provided:

The 12 months preceding the month in which the application is submitted **OR** the previous calendar year in which the application is submitted

What 12 month time period does this income documentation represent: _____ to _____
(month/year) (month/year)

Name of Person in Family	Income Source (One line per source) (Employer)	Documentation (W2, Tax Return, Check Stub, Letter, etc)	Time Frame Covered by this Source	Amount (Show calculation where necessary)

Number of Persons in Household: _____ Total Annual Income of Family: $_____
Is family at or below 100% of Poverty Guidelines? YES NO If family is over income, the Over Income Referral & Approval must be submitted.

Notes: _____

PARENT/GUARDIAN CERTIFICATION & SIGNATURE

*I **certify** that all of the information contained within this FAMILY PARTNERSHIP AGREEMENT is true and accurate to the best my knowledge. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. Information shared with agency staff will be kept strictly confidential and maintained in locked files.*

Certifico que toda la información contenida en este acuerdo de Asociación de la familia es verdadera y exacta a la mejor de mi conocimiento. Si alguna parte es falsa, mi participación en los programas de esta agencia puede ser terminada y yo podría estar sujeto a acciones legales. La información compartida con el personal de la agencia se mantendrá estrictamente confidencial y mantenida en archivos bloqueados.

1st YEAR - Parent/Guardian Signature: _____ Date: _____

Verifying Staff Member: _____ Date: _____

GSRP ONLY

Section 10: Please sign below if you give permission for this application and related documentation that you provide to be confidentially shared with other free or sliding-scale-tuition prekindergarten programs in the area for the purpose of placing your child.
Signature* of Parent/Guardian: _____ **Date:** _____
* If via phone, staff will check this box and initial☐ _____; and print the parent/guardian name above with date

*I have **reviewed and updated** the information contained within this FAMILY PARTNERSHIP AGREEMENT and **certify** that it is true and accurate to the best my knowledge. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. Information shared with agency staff will be kept strictly confidential and maintained in locked files.*

He revisado y actualizado la información contenida en este acuerdo de asociación familiar y certifico que es verdadero y exacto a lo mejor de mi conocimiento. Si alguna parte es falsa, mi participación en los programas de esta agencia puede ser terminada y yo podría estar sujeto a acciones legales. La información compartida con el personal de la agencia se mantendrá estrictamente confidencial y mantenida en archivos bloqueados.

2nd YEAR - Parent/Guardian Signature: _____ Date: _____

Verifying Staff Member: _____ Date: _____

GSRP ONLY

Section 10: Please sign below if you give permission for this application and related documentation that you provide to be confidentially shared with other free or sliding-scale-tuition prekindergarten programs in the area for the purpose of placing your child.
Signature* of Parent/Guardian: _____ **Date:** _____
* If via phone, staff will check this box and initial☐ _____; and print the parent/guardian name above with date