**ROCK-WALWORTH HEAD START/EARLY HEASDSTART**

**PRE-NATAL APPLICATION- Program Year 2025-2026**

Thank you for your interest in our Early HeadStart Program. A healthy pregnancy has a direct influence on the health and development of a newborn child. Early HeadStart strives to have the greatest impact on children and families by offering supportive services as early in life as possible.

Services to pregnant women and their families are provided through the child's first three years of life. The prenatal period of growth and development has a lasting impact on the child's potential for healthy growth and development after birth. The home visit program incorporates the following:

- **Healthy pregnancies and positive childbirth outcomes;**
- **Supportive postpartum care for the parents and child;**
- **Fully involving fathers in the lives of their young children; and**
- **Nurturing and responsive care during infancy.**

Specialized services are available by certified Doulas for pregnant and postpartum moms (this service is currently **only available in Rock County and space is limited). 2024 proof of income and an interview** are required to determine your eligibility for the program. Completing the application does not mean you are automatically accepted. Pregnant moms with the greatest need for services will be placed first. Please complete the application thoroughly so we know how best to serve you.

**ALL INFORMATION IS CONFIDENTIAL.**

**WE ARE AN INCOME BASED PROGRAM AND WILL NEED YOUR 2024 INCOME:**

If you *currently* receive **ONE** of the following, we will need verification.
Example: award letter or current statement.

**►SSI ►W2 Cash Assistance ►Food Stamps/Food Share ► Foster Care/ Kinship Care**

**If none of these apply to you, please send a copy of all incomes below that apply:**

**● 2024 Tax Return ● 2024 W2 Employer Statement(s) ● SSDI ● Caretaker's Supplement**
**● 2024 Child Support received for all children in the home ● Unemployment**
**● Earnings statement from the employer ● Written statement for cash earnings**

**If none of these apply to you, please contact the enrollment office.**

**Incomplete applications are NOT considered for placement. Please call us with any new contact information.**

**WE CAN'T SERVE YOU IF WE CAN'T FIND YOU!!!**

**If you have any questions or need help with anything, please call/email us:**


**Bri O'Brien** — bobrien@cfsheadstart.org

**Nancy Marx** — nmarx@cfsheadstart.org

**Dee Cervantes** — dcervantes@cfsheadstart.org

**1221 Henry Ave, Beloit, WI 53511 ● Phone: (608) 299-1500 or 1-800-774-7778 ● Fax: (608) 299-1629**

**CONFIDENTIAL PRE-NATAL APPLICATION FOR ENROLLMENT PY 2025-2026**
THIS APPLICATION SHOULD ONLY BE FILLED OUT AND SIGNED BY THE PRE-NATAL PARENT
**PEN ONLY PLEASE!**

## 1. PREGNANT PARENT INFORMATION:

**NAME:** _____ **DOB:** _____
First Last

**HOME ADDRESS:** _____

**PRIMARY PHONE**_____ H C W Opt in for text messages: □ Yes □No

**EMAIL ADDRESS:** _____

**DO YOU WORK AT HEADSTART OR A COLLABORATIVE PARTNER?** □ Yes □No

**RACIAL/ETHNIC BACKGROUND:**

□White □American Indian/ Alaska Native □Hispanic

□Black/ African American □Native Hawaiian/Other Pacific Islander □ Asian

□ Other: _____

| | |
|---|---|
| Primary Language: ☐English ☐Spanish ☐American Sign Language ☐Other:_____ | |
| Education | Completed Elementary School: ☐ Yes ☐ No Some College or Degree ☐ Yes ☐ No<br>Received: ☐ High School Diploma ☐ HSED/GED ☐ None Highest Grade:_____ |

## 2. PREGNANCY INFORMATION

What trimester of pregnancy are you in: ☐ 1st ☐2nd ☐3rd Due Date:_____
Number of past pregnancies (Do not include your current pregnancy):_____ Number of live births: _____
Have you ever been pregnant with multiples? ☐ Yes ☐No Are you receiving prenatal care: ☐Yes ☐No
Do you or your doctor have any concerns with your pregnancy? ☐ Yes ☐No
Concerns: _____

## 3. SECOND PARENT INFORMATION

**NAME:** _____ **DOB:**_____
Race/Ethnicity:_____ Hispanic: ☐ Yes ☐No
Address if different than child's family: _____
Primary Phone: _____ H C Opt in for text messages: ☐ Yes ☐No
Secondary Phone: _____ H C W Email: _____
Primary Language: _____ Completed Elementary School: ☐Yes ☐No
Received: ☐ High School Diploma ☐HSED/GED ☐None Highest Grade: _____
Some College or Degree ☐ Yes ☐No

## 4. MARITAL STATUS OF BIRTH PARENTS:

☐ Married/Living Together ☐ Legally Married/Not Living Together ☐Divorced
☐ Never Married/Living Together ☐ Never Married/Not Living Together ☐ Widowed

## 5. CURRENT LIVING ARRANGEMENT:

☐ Rent ☐ Own ☐Staying with family/friends long term ☐Foster Home ☐Other: _____

☐ I am homeless. Meaning you are staying in a car, park, campgrounds, hotel, emergency shelter, transitional living, on the street, or are living with family/friends short term. **If homeless, please circle which applies to you:**

## 6. DO YOU HAVE ANY FAMILY CONCERS?

| | | |
|---|---|---|
| ☐ Reading | ☐ Writing | ☐ Parent has/had an IEP |
| ☐ Continuing Education | ☐ Transportation | ☐ Parent has a chronic/terminal illness |
| □ Mental Health | ☐ Not enough food in the home | ☐ Housing Instability |
| ☐ House Fire | ☐ Frequent Moves (2+ a yr.) | ☐ Immigration Concerns |
| ☐ Unemployed / Not enough hours | ☐ Alcohol / Drug use | ☐ Legal Concerns |
| ☐ One parent is incarcerated | ☐ Both parents are incarcerated | ☐ One or both parents are deceased |

☐ Currently employed and in need of childcare ☐ Other: _____ ☐ None

## 7. HOW DID YOU FIND OUT ABOUT US?

| | | |
|---|---|---|
| □ Day Care | □ Birth-3 | □ School Staff |
| □ Early Head Start/ Head Start | □ Job Center Rock/Walworth Co | □Doctor |
| □ Social Media/Internet | □ Counselor | □ Children's WI Resource Center |
| □ Friend/Family | □ Community Health Program/WIV | □ Autism Service Provider |
| □ Billboard □ Yard Sign | □ Health & Human Services | □ Domestic Violence Shelter |

## 8. DOES ANY MEMBER OF THE HOUSEHOLD RECEIVE ANY OF THE FOLLOWING? (Check all that apply)

| | | |
|---|---|---|
| □ Foster/Kinship Care | □ Health Insurance (State/Private) | □ Child Support (any child in home) |
| □ Supplemental Security Income (SSI) | □ Caretaker Supplement | □ Survivor Benefit □WIC |
| □W2/ Cash Assistance | □ Social Security/ Disability (SSDI) | □ Energy Assistance |
| □ Food Share/Food Stamps/ SNAP | □ Rental Assistance (Section 8) | □ Childcare Assistance □ None |

## 9. ADDITIONAL CONTACT PERSON(S) IN CASE WE CANNOT REACH YOU:

1. _____
Name Relationship to child Phone

2. _____
Name Relationship to child Phone

## 10. LIST SIBLINGS TO THE UNBORN CHILD IN THE HOUSEHOLD:

(First) (Last) (Relationship to child)

1. _____ □ Male □ Female DOB: _____
2. _____ □ Male □ Female DOB: _____
3. _____ □ Male □ Female DOB: _____

4. _____ □ Male □ Female DOB: _____

5. _____ □ Male □ Female DOB: _____

PLEASE READ THE STATEMENTS BELOW CAREFULLY BEFORE SIGNING:

**Application will not be complete until we have proof of income.**

Family income is the income of the biological parent(s)/ adoptive parent(s) or guardian(s) living in the household. For enrollment purposes, I understand that RWCFS Head Start- Early Head Start may need to coordinate programming with my local school district, and other home visitation programs for placement. By signing, I verify that the information provided is correct and complete to the best of my knowledge. I further understand that if I knowingly provide false information that my family may no longer be eligible for services.

**Non-discriminatory Clause: RWCFS HS & EHS policy is not to discriminate based on race, sex, age, color, national origin, religion, or disabilities in the provision of services and employment.**

SIGN AND DATE:

Parent/Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY:

**Interview:** ☐ In Person ☐Phone Staff Initials: _____ Date: _____

**Interview completed with:** _____

**Documents Received:** ☐Income-Proof of eligibility provided: _____

| INCOME POINTS: | TOTAL POINTS: | DATA ENTERED BY: | REVIEWED BY: |
|---|---|---|---|
| | | | |