Child and Family Development Programs

Early Head Start/Head Start/State Pre-K

225 Westridge Drive, Watsonville, CA 95076

Office: (831)724-3885/(831)688-3802 Fax: (833)204-4892 Email: ERSEAIntakeApplication@EncompassCS.org

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Thank you for your interest in our Pregnant Woman program. Our high quality Pregnant Woman program is available to women living in Santa Cruz County. To qualify for our services you must be income or categorically eligible.

If you have any questions about the application, or documents required, or need assistance in completing this application, please let us know. **We will be happy to assist you!**

Income Eligibility

- You are eligible if your income meets the current year Federal Poverty Guidelines.

Categorical (*automatic*) Eligibility

- If you are receiving benefits or services through the CalWORKs program **OR**
- A family member living with and supported by you is receiving Supplemental Security Income (SSI) **OR**
- The family considers themselves homeless *(per the definition of the McKinney-Vento Homeless Act).*

Required documents to determine eligibility

Please submit your **completed application** with copies of the following documents (*document will not be returned*):

- **Income documents**: Documents must include all sources of income received by you and spouse/partner *(see income Eligibility section of application for more detailed information).*
- **Pregnancy verification**: Letter from doctor and/or ultrasound printout.

(*Note: Your application will not be processed without the above documents*)

Submitting your Application

All information is kept confidential. The information you provide us will assist us in determining if you're eligible for our Pregnant Woman program and to prioritize *(using our selection criteria point system)* your placement on the wait list.

You can submit your application in person or mail it to the address above. Our Intake Staff will contact you regarding your application.

CFDP Child Development Programs does not discriminate against children or families on the basis of race, color, national origin, gender religion, age disability, political beliefs, sexual orientation, and marital or family status.

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PREGNANT WOMAN'S APPLICATION
(*Confidential*)

How did you hear about our program (√)?

☐ Friend of Family ☐ Community Agency ☐ Community Event ☐ Print Advertisement ☐ Internet ☐ Other: ____________________

PREGNANT WOMAN'S INFORMATION			
First Name:	Last Name:	Birth Date:	Language spoken at home?
Home Address:		City/Zip Code:	
Mailing Address:		City/Zip Code:	
Home Phone #:	Cell Phone #:	Email address:	
☐Married ☐Single ☐Divorced ☐Separated ☐Widow		Occupation:	
Are you currently in the United States military? ☐ Yes ☐ No		Are you an employee of Encompass Community Services (√)? ☐ Yes ☐ No *If yes, which program?*	
Are you related to an employee of this program/agency (√)? ☐ Yes ☐ No *If yes, who?*		In what language do you prefer written materials (√)? ☐ English ☐ Spanish	
SPOUSE/PARTNER'S INFORMATION			
First Name:	Last Name:	Birth Date:	Language spoken at home?
Home Address:		City/Zip Code:	
Mailing Address:		City/Zip Code:	
Home Phone #:	Cell Phone #:	Email address:	
Occupation:		Are you related to an employee of this program/agency (√)? ☐ Yes ☐ No *If yes, who?*	
Are you currently in the United States military? ☐ Yes ☐ No		Are you an employee of Encompass Community Services (√)? ☐ Yes ☐ No *If yes, which program?*	

FAMILY SIZE

Please list all people in the household (***do not list "yourself or spouse/partner"***) who are supported by your/your spouse's/partner's income *(if you need more room, please use another sheet of paper).*

Name	**Date of Birth**	**Relationship to you**	**Live in the Home (*yes/no*)**
1.			
2.			
3.			
4.			
5.			
6.			

Total number of people living in household (*including yourself*) for whom you provide financial support? ☐

PREGNANCY VERIFICATION

Are you receiving prenatal care (√): ☐ Yes ☐ No | Number of months pregnant: | Expected delivery date:

Name of Obstetrician/Clinic: | Name of Dentist:

Are you covered by Medi-Cal (√)? ☐ Yes ☐ No | Are you covered by Private Health Insurance (√)? ☐ Yes ☐ No

Are you under a doctor's care for any of the following (√)?

☐ High Blood Pressure ☐ Anemia ☐ Diabetes ☐ Nausea ☐ Other:

Are you currently receiving services from another Home Visit program (√)? ☐ Yes ☐ No If yes, which program?

FAMILY CIRCUMSTANCES

Please indicate (√) any events which have occurred in your family within the last 2 years.

☐ Death in the family ☐ Serious illness in the family ☐ Divorce/Separation ☐ Military deployment ☐ Homelessness

☐ Incarceration of parent/guardian ☐ Grandparent/s Relatives raising child (*kinship care*) ☐ Other, please explain: ________________________

Were you referred to our program? (√) ☐ Yes ☐ No If yes, by whom? (√): ☐ Doctor/clinic ☐ Public Health Nurse ☐ Side-by-Side

☐ Counselor/therapist ☐ PVUSD-Cal-SAFE ☐ Local School District ☐ Papá's Program ☐ CPS ☐ Other: ______________________

INCOME ELIGIBILITY QUESTIONS

Is your family currently receiving TANF benefits (√)? .... ☐ Yes ☐ No
(TANF benefits include on-going TANF/CalWORKS cash grant and/or Welfare-to-Work non-cash aid)
If yes, attach documentation that you are currently receiving TANF benefits.

Are you or anyone in your family currently receiving Supplemental Security Income (*SSI*) (√)? .... ☐ Yes ☐ No
If yes, attach documentation that you or someone in your family is currently receiving SSI benefits.

Is your family currently homeless (√)? .... ☐ Yes ☐ No
(living temporarily in transitional housing, shelters, hotels, or vehicles; or moving frequently between the home of relatives and friends)
You may be asked to provide verification that you are receiving homeless services.

Do you receive income from wages (√)? .... ☐ Yes ☐ No
(income tax report (1040-A form), W2's, all paystubs received in the last 12 months, or letter from employer)
If yes, attach documentation of income you received last calendar year or for the past 12 months.

Do you receive Child Support, Disability, Unemployment or Worker's Compensation (√)?.................... ☐ Yes ☐ No
If yes, attach documentation of income you received for the past 12 months.

Applicant's paydays (√): ☐ Weekly ☐ Every 2 weeks ☐ Twice per month ☐ Monthly

Spouse/partner's Paydays (√): ☐ Weekly ☐ Every 2 weeks ☐ Twice per month ☐ Monthly

APPLICANT'S SIGNATURE

I certify that all the information in this application and income provided is correct. I understand that if any false information is given, my application may be disqualified or services discontinued.

Signature: ____ Date: ________________________