Holy Cross Head Start

150 Maryland St., Buffalo, NY 14201
(716) 852-8373

Pre-Application Date: _____

Child Information:

Child's Name: _____ Birthdate: _____

Gender: _____ Ethnicity: _____ Language: _____

Address: _____

Circle One: Foster Child: Yes or No Does child have an IEP: Yes or No

Parent/Guardian Information:

Name: _____ Birthdate: _____

Gender: _____ Ethnicity: _____ Language: _____

Relation to Child: _____

Address: _____

Phone Number: _____ E-mail Address: _____

Circle One: House or Apartment Own or Rent Other (specify): _____

Circle One: Married or Single Currently pregnant: Yes or No

Highest Level of School Complete: _____

Circle One: Working: PT or FT or Military or Not Working School: PT or FT or Not in School

Type of Income: Earned Wages or TANF or SSI or Other (specify): _____

Annual Gross Income: _____ Circle if you receive: WIC Medicaid Food Stamps

Please list all additional people living in your household:

Name	Relation to Child	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has anyone in the household previously attended Head Start or Early Head Start? _____

How did you hear about our program? _____

Center Preference: _____

Staff Name: _____