

**Coquille Indian Tribe Head Start Program**  
**Enrollment Application**

The recruitment area for the Coquille Indian Tribe Head Start Program includes children and families from the Coquille Indian Tribe’s Kilkich Community, as well as neighboring communities of Coos Bay, North Bend, and the surrounding community. Recruitment and enrollment also include Native American families and others as approved by the Coquille Indian Tribe Tribal Council and the Coquille Indian Tribe Head Start Policy Council Committee.

**Child Information**

Child’s Name \_\_\_\_\_ Birthdate \_\_\_\_\_

**Diagnosed disabilities or special needs:**

Speech     Hearing     Vision     Social development

**Child lives with:**

Mother and Father     One parent     Joint custody     Foster family  
 Active-Duty Personnel     Other relative

**Family Information**

Mother’s Name \_\_\_\_\_ D.O.B \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Message Phone \_\_\_\_\_

Father’s Name \_\_\_\_\_ D.O.B \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Message Phone \_\_\_\_\_

**Childcare after school:**

Yes     No

Name of childcare provider: \_\_\_\_\_ Phone \_\_\_\_\_

Total number in Family \_\_\_\_\_ Adults \_\_\_\_\_ Children \_\_\_\_\_

**List all other children living in the home:**

Name	Birthdate

**Does your family receive services from any of the following agencies? (Check those that apply.)**

- |  |  |
|--|--|
| <input type="checkbox"/> Services to Children & Families (SCF/CSD)   | <input type="checkbox"/> Women's Crisis Services |
| <input type="checkbox"/> Oregon Coast Community Action               | <input type="checkbox"/> Legal Aid               |
| <input type="checkbox"/> Adult and Family Services                   | <input type="checkbox"/> Health Department       |
| <input type="checkbox"/> Education Service District (ESD)            | <input type="checkbox"/> SNAP                    |
| <input type="checkbox"/> South Coast Business Employment Corporation | <input type="checkbox"/> Mental Health           |
| <input type="checkbox"/> WIC (Women, Infants, Children Nutrition)    | <input type="checkbox"/> Other _____             |

**Racial or Ethnic Group**

- |  |   |
|--|---|
| <input type="checkbox"/> White, not of Hispanic origin | <input type="checkbox"/> Hispanic         |
| <input type="checkbox"/> Black, not of Hispanic origin | <input type="checkbox"/> Asian            |
| <input type="checkbox"/> American Indian               | <input type="checkbox"/> Pacific Islander |
| <input type="checkbox"/> Alaskan Native                | <input type="checkbox"/> Other _____      |

**Eligibility Information (please check all that apply)**

**Child is:**

- Enrolled Coquille Tribal Member      Enrollment number \_\_\_\_\_
- Enrolled Native American (Non-Coquille)  
Name of Federally Recognized Tribe \_\_\_\_\_      Enrollment number \_\_\_\_\_

- Legally step or adopted child three to five years of age living in a Coquille Indian Tribal/Native American home.
- In foster care.
- Child with a disability.
- Child who resides in Kilkich Community (Coquille Indian Tribe reservation land).
- Child legally placed in a Coquille Indian Tribal home through the Coquille Indian Tribal Court.
- Child of parent who is employed by the Coquille Indian Tribe.

**Financial Eligibility:**

To help us determine if your family is eligible for Head Start, we need to know your GROSS income. Please submit one paystub **OR** your income as entered on last year's income tax returns.

**Examples:** Income tax form 1040, W-2 form, pay stub, pay envelope, written statement from employer, documentation that shows you receive unemployment or public assistance.

**Types of income (please check all that apply):**

- |   |   |                                      |
|---|---|--------------------------------------|
| <input type="checkbox"/> No Income            | <input type="checkbox"/> Child Support      | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Wages                | <input type="checkbox"/> Social Security    |                                      |
| <input type="checkbox"/> Self-Employed Income | <input type="checkbox"/> Unemployment       |                                      |
| <input type="checkbox"/> Public Assistance    | <input type="checkbox"/> Veteran's Benefits |                                      |

**Medical Insurance:**

- |                                   |  |   |
|-----------------------------------|--|---|
| <input type="checkbox"/> None     | <input type="checkbox"/> Private                   | <input type="checkbox"/> Oregon Health Plan (OHP) |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Purchased & Referred Care |   |

**Dental Insurance:**

- |                                   |  |   |
|-----------------------------------|--|---|
| <input type="checkbox"/> None     | <input type="checkbox"/> Private                   | <input type="checkbox"/> Oregon Health Plan (OHP) |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Purchased & Referred Care |   |

I have read this application form and understand it. I verify that all information and documentation are accurate to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date