



2026-2027



O.V.O. Head Start FREE Pre-School

Head Start determines eligibility by a priority system including:

- Child's Age (must be 3 or 4)
- Family Income
- Identified special needs of the child and/or family

All of our classes are Full Day and are 4 days a week.

The child **DOES NOT** have to be potty trained!

No school supplies (or backpacks) needed!

If you have questions, want to pick up, or turn in an application please visit your local center:

Hanover

273 S Main Cross St
Hanover, IN 47243
Phone: 812-599-4887

Madison

575 OVO Drive
Madison, IN 47250
Phone: 812-265-8240
Cell: 812-599-4659

North Vernon

3040 N. Hwy 3
North Vernon, IN 47265
Phone: 812-346-8965
Cell: 812-599-2850

Scottsburg

1172 Community Way
Scottsburg, IN 47170
Phone: 812-752-7409
Cell: 812-599-4498

Head Start Administration Office

ATTN: Enrollment
P.O. Box 625
Madison, IN 47250
Phone: 812-265-4877
Fax: 812-273-5950

Applications CANNOT BE PROCESSED without the following information:

1. A completed application
2. A copy of your Child's Birth Certificate
3. Total Family Income- Include **any** of the following:

- | | |
|---------------------------|---------------------------------|
| Most Recent Tax Return | SSI |
| Workers Comp. | Social Security |
| W-2s | Child Support |
| Check Stubs | Veterans Benefits |
| Unemployment | Disability (Short or Long Term) |
| Self Employment | Pension |
| TANF | Retirement |
| Employer Wage Statement | SNAP award letter |
| *Any other regular income | |

If the Child is a Foster child/ Ward of State- include DCS letter.

If you DO NOT HAVE ANY INCOME please call your local center.

Please notify us if your address or phone number changes!

Returning Child

O.V.O Head Start Application

Year: 2026-2027

Section A Child Information (Applying for services)

Legal First Name:	Legal Middle Name:	Legal Last Name:	Suffix:
Preferred Name:	Birthday:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Race: <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Bi or Multi-Racial <input type="checkbox"/> Other _____	Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Language: <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient	Secondary Language: <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient
Primary Health Coverage:	Health Coverage Provider:	Health Coverage Number:	

Section B Primary Adult

Legal First Name:	Legal Middle Name:	Legal Last Name:	Birthday:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Health Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No	Lives with Child: <input type="checkbox"/> Yes <input type="checkbox"/> No	Custody: <input type="checkbox"/> Yes <input type="checkbox"/> No
Race: <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Bi or Multi-Racial <input type="checkbox"/> Other _____	Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Language: <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient	Secondary Language: <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient
Highest Grade Completed: <input type="checkbox"/> Grade 9 or below <input type="checkbox"/> Some College <input type="checkbox"/> GED <input type="checkbox"/> Grade 10 <input type="checkbox"/> Technical Certificate <input type="checkbox"/> Grade 11 <input type="checkbox"/> Associate's <input type="checkbox"/> Grade 12 (non grad) <input type="checkbox"/> Bachelor's <input type="checkbox"/> High School Grad <input type="checkbox"/> Master's		Employment Status: <input type="checkbox"/> Retired <input type="checkbox"/> Seasonal <input type="checkbox"/> Disabled <input type="checkbox"/> School/ Training <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time <input type="checkbox"/> Unemployed (6 months or less) <input type="checkbox"/> Unemployed (7 months or more)	Relationship to Child: <input type="checkbox"/> Biological, Adopted, Stepchild <input type="checkbox"/> Grandchild <input type="checkbox"/> Niece/Nephew <input type="checkbox"/> Foster <input type="checkbox"/> Other
Email:		If employed: Where?	

Section C Secondary Adult

Legal First Name:	Legal Middle Name:	Legal Last Name:	Birthday:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Health Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No	Lives with Child: <input type="checkbox"/> Yes <input type="checkbox"/> No	Custody: <input type="checkbox"/> Yes <input type="checkbox"/> No
Race: <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Bi or Multi-Racial <input type="checkbox"/> Other _____	Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Language: <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient	Secondary Language: <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient
Highest Grade Completed: <input type="checkbox"/> Grade 9 or below <input type="checkbox"/> Some College <input type="checkbox"/> GED <input type="checkbox"/> Grade 10 <input type="checkbox"/> Technical Certificate <input type="checkbox"/> Grade 11 <input type="checkbox"/> Associate's <input type="checkbox"/> Grade 12 (non grad) <input type="checkbox"/> Bachelor's <input type="checkbox"/> High School Grad <input type="checkbox"/> Master's		Employment Status: <input type="checkbox"/> Retired <input type="checkbox"/> Seasonal <input type="checkbox"/> Disabled <input type="checkbox"/> School/ Training <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time <input type="checkbox"/> Unemployed (6 months or less) <input type="checkbox"/> Unemployed (7 months or more)	Relationship to Child: <input type="checkbox"/> Biological, Adopted, Stepchild <input type="checkbox"/> Grandchild <input type="checkbox"/> Niece/Nephew <input type="checkbox"/> Foster <input type="checkbox"/> Other
Email:		If employed: Where?	

Section D Additional Family Members living in the home full time

Legal First Name:		Legal Middle Name:		Legal Last Name:		Birthday:			
Gender:		Health Insurance:		Disabled:		Relationship to Child:		Highest Grade Completed:	
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Race:				Hispanic:		Primary Language:			
<input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native				<input type="checkbox"/> Yes					
<input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander				<input type="checkbox"/> No		<input type="checkbox"/> Little			
<input type="checkbox"/> White <input type="checkbox"/> Bi or Multi-Racial						<input type="checkbox"/> Moderate			
<input type="checkbox"/> Other _____						<input type="checkbox"/> Proficient			
Legal First Name:		Legal Middle Name:		Legal Last Name:		Birthday:			
Gender:		Health Insurance:		Disabled:		Relationship to Child:		Highest Grade Completed:	
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Race:				Hispanic:		Primary Language:			
<input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native				<input type="checkbox"/> Yes					
<input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander				<input type="checkbox"/> No		<input type="checkbox"/> Little			
<input type="checkbox"/> White <input type="checkbox"/> Bi or Multi-Racial						<input type="checkbox"/> Moderate			
<input type="checkbox"/> Other _____						<input type="checkbox"/> Proficient			
Legal First Name:		Legal Middle Name:		Legal Last Name:		Birthday:			
Gender:		Health Insurance:		Disabled:		Relationship to Child:		Highest Grade Completed:	
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Race:				Hispanic:		Primary Language:			
<input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native				<input type="checkbox"/> Yes					
<input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander				<input type="checkbox"/> No		<input type="checkbox"/> Little			
<input type="checkbox"/> White <input type="checkbox"/> Bi or Multi-Racial						<input type="checkbox"/> Moderate			
<input type="checkbox"/> Other _____						<input type="checkbox"/> Proficient			
Legal First Name:		Legal Middle Name:		Legal Last Name:		Birthday:			
Gender:		Health Insurance:		Disabled:		Relationship to Child:		Highest Grade Completed:	
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Race:				Hispanic:		Primary Language:			
<input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native				<input type="checkbox"/> Yes					
<input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander				<input type="checkbox"/> No		<input type="checkbox"/> Little			
<input type="checkbox"/> White <input type="checkbox"/> Bi or Multi-Racial						<input type="checkbox"/> Moderate			
<input type="checkbox"/> Other _____						<input type="checkbox"/> Proficient			
Legal First Name:		Legal Middle Name:		Legal Last Name:		Birthday:			
Gender:		Health Insurance:		Disabled:		Relationship to Child:		Highest Grade Completed:	
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Race:				Hispanic:		Primary Language:			
<input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native				<input type="checkbox"/> Yes					
<input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander				<input type="checkbox"/> No		<input type="checkbox"/> Little			
<input type="checkbox"/> White <input type="checkbox"/> Bi or Multi-Racial						<input type="checkbox"/> Moderate			
<input type="checkbox"/> Other _____						<input type="checkbox"/> Proficient			
Legal First Name:		Legal Middle Name:		Legal Last Name:		Birthday:			
Gender:		Health Insurance:		Disabled:		Relationship to Child:		Highest Grade Completed:	
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Race:				Hispanic:		Primary Language:			
<input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native				<input type="checkbox"/> Yes					
<input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander				<input type="checkbox"/> No		<input type="checkbox"/> Little			
<input type="checkbox"/> White <input type="checkbox"/> Bi or Multi-Racial						<input type="checkbox"/> Moderate			
<input type="checkbox"/> Other _____						<input type="checkbox"/> Proficient			

Section E Family Information								
Living Address:			Mailing Address:			Housing:		
Address:			Address:			<input type="checkbox"/> Own/Buying <input type="checkbox"/> Rent <input type="checkbox"/> Other		
City: IN Zip:			City: IN Zip:					
County:			County:					
Phone Numbers:						* If given permission to message a phone number standard text messaging rates may apply.		
() -		() -		() -				
Whose: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work *If cell checked may we message? <input type="checkbox"/> Yes <input type="checkbox"/> No		Whose: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work *If cell checked may we message? <input type="checkbox"/> Yes <input type="checkbox"/> No		Whose: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work *If cell checked may we message? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Parental Status:	Homeless:	Active Military	Military Veteran	Referred by Child Welfare agency	Receiving SNAP (Food Stamps)	Receiving WIC	TANF	SSI
<input type="checkbox"/> One Parent <input type="checkbox"/> Two Parent	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section F Income				
Family Member	Description (example SSI, job, child support)	Verification (example W2, check stub)	Amount	Week, Month, Year?
			\$ per	
			\$ per	
			\$ per	
			\$ per	

Section G Child Information <i>The following questions are to provide the best services possible for your child.</i>		
Does your child have any current or chronic medical conditions? (Example asthma, heart problems, diabetes, bronchitis, seizures, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, List/explain:
Does your child have an active Individual Education Plan (IEP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, List/explain:
Does your child have any speech/language delays?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, List/explain:
Does your child have any emotional problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, List/explain:
Does your child have any visual problems/blindness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, List/explain:
Does your child have any movement problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, List/explain:
Does your child have any hearing issues?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, List/explain:
Does your child have a developmental delay?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, List/explain:
Has your child been tested or referred by another agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, List/explain:
Does your child have any diagnosed food or medical allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, List/explain:
Do you have any health concerns about your child?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, List/explain:
Do you have any developmental concerns about your child?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, List/explain:
Does your child take any prescription medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, List/explain:
Is your child receiving counseling or mental health services?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, List/explain:
Has your child received a mental health evaluation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, List/explain:

Check all that apply to anyone currently living in your home:

- | | | |
|--|--|---|
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Mental Abuse | <input type="checkbox"/> Parent/Sibling Documented Disability |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Ward of Court | <input type="checkbox"/> Absent/Deceased parent |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Unsafe/unstable living conditions | |

Has this child been to any other preschool program before?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, where
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How did you hear about Head Start?

Is there anything you would like for us to know about your child or family?

Certification: I certify that this information is true and correct to the best of my knowledge. I authorize certification of the information I have provided. I understand that I could be prosecuted for providing false information. I also understand that the information in this application will be held in strict confidence within the agency.

Parent/Guardian Signature

Date

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Central Office Staff Use ONLY

Date:	<input type="checkbox"/> In person interview	<input type="checkbox"/> Phone/ Virtual Interview	Staff Initials:		
Application complete?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	*If no is checked, mark what info is needed below		
Info Needed	<input type="checkbox"/> Income	<input type="checkbox"/> BC	<input type="checkbox"/> Shot record	<input type="checkbox"/> Insurance Card	<input type="checkbox"/> Disability Info
<input type="checkbox"/> Other	_____				
Completed Application Date:	_____				
<input type="checkbox"/> Accepted	<input type="checkbox"/> Wait List	<input type="checkbox"/> Enrolled	Class		
<input type="checkbox"/> Over Income	<input type="checkbox"/> 2 year old	<input type="checkbox"/> Other note			
ChildPlus ID#	Application entered by:	Date:			

Staff: Refer to birth certificate and verify with parent.

Child's first name: _____ Child's last name: _____

Child's birthday: _____