



# 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: 812-866-1176

Fax: 812-866-1115

Madison

575 OVO Drive

Madison, IN 47250

Phone: 812-265-8240

Fax: 812-265-0076

North Vernon

3040 N. Hwy 3

North Vernon, IN 47265

Phone: 812-346-8965

Fax: 812-346-6265

Scottsburg

1172 Community Way

Scottsburg, IN 47170

Phone: 812-752-7409

Fax: 812-754-1709

Head Start Administration Office

ATTN: Enrollment

P.O. Box 625

Madison, IN 47250

Phone: 812-265-4877

Fax: 812-273-5950

Email: [mkimmel@ovoinc.org](mailto:mkimmel@ovoinc.org)

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

Workers Comp.

W-2s

Check Stubs

Unemployment

Self Employment

TANF

Employer Wage Statement

\*Any other regular income

SSI

Social Security

Child Support

Veterans Benefits

Disability (Short or Long Term)

Pension

Retirement

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!

¿No hablas ingles? Llame al centro de Hanover. (812-866-1176)

Returning Child

O.V.O Head Start Application

Year: 2021-2022

<b>Section A Child Information (Applying for services)</b>							
Legal First Name:		Legal Middle Name:		Legal Last Name:		Suffix:	
Preferred Name:		Birthday:		Gender:			
				<input type="checkbox"/> Male <input type="checkbox"/> Female			
Race:		Hispanic:	Primary Language:		Secondary Language:		
<input type="checkbox"/> Asian <input type="checkbox"/> Indian/Alaska Native		<input type="checkbox"/> Yes	<input type="checkbox"/> Little		<input type="checkbox"/> Little		
<input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander		<input type="checkbox"/> No	<input type="checkbox"/> Moderate		<input type="checkbox"/> Moderate		
<input type="checkbox"/> White <input type="checkbox"/> Bi or Multi-Racial			<input type="checkbox"/> Proficient		<input type="checkbox"/> Proficient		
<input type="checkbox"/> Other							
Primary Health Coverage:		Health Coverage Provider:		Health Coverage Number:			
<b>Section B Primary Adult</b>							
Legal First Name:		Legal Middle Name:		Legal Last Name:		Birthday:	
Gender:		Health Insurance:		Lives with Child:		Custody:	
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Race:		Hispanic:	Primary Language:		Secondary Language:		Marital Status:
<input type="checkbox"/> Asian <input type="checkbox"/> Indian/Alaska Native		<input type="checkbox"/> Yes	<input type="checkbox"/> Little		<input type="checkbox"/> Little		<input type="checkbox"/> Single
<input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander		<input type="checkbox"/> No	<input type="checkbox"/> Moderate		<input type="checkbox"/> Moderate		<input type="checkbox"/> Married
<input type="checkbox"/> White <input type="checkbox"/> Bi or Multi-Racial			<input type="checkbox"/> Proficient		<input type="checkbox"/> Proficient		<input type="checkbox"/> Separated/ Divorced
<input type="checkbox"/> Other							<input type="checkbox"/> Living Together
Highest Grade Completed:			Employment Status:			Relationship to Child:	
<input type="checkbox"/> Grade 9 or below <input type="checkbox"/> Some College <input type="checkbox"/> GED			<input type="checkbox"/> Retired <input type="checkbox"/> Seasonal			<input type="checkbox"/> Biological, Adopted, Stepchild	
<input type="checkbox"/> Grade 10 <input type="checkbox"/> Technical Certificate			<input type="checkbox"/> Disabled <input type="checkbox"/> School/ Training			<input type="checkbox"/> Grandchild	
<input type="checkbox"/> Grade 11 <input type="checkbox"/> Associate's			<input type="checkbox"/> Part Time <input type="checkbox"/> Full Time			<input type="checkbox"/> Niece/Nephew	
<input type="checkbox"/> Grade 12 (non grad) <input type="checkbox"/> Bachelor's			<input type="checkbox"/> Unemployed (6 months or less)			<input type="checkbox"/> Foster	
<input type="checkbox"/> High School Grad <input type="checkbox"/> Master's			<input type="checkbox"/> Unemployed (7 months or more)			<input type="checkbox"/> Other	
Email:				If employed: Where?			
<b>Section C Secondary Adult</b>							
Legal First Name:		Legal Middle Name:		Legal Last Name:		Birthday:	
Gender:		Health Insurance:		Lives with Child:		Custody:	
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Race:		Hispanic:	Primary Language:		Secondary Language:		Marital Status:
<input type="checkbox"/> Asian <input type="checkbox"/> Indian/Alaska Native		<input type="checkbox"/> Yes	<input type="checkbox"/> Little		<input type="checkbox"/> Little		<input type="checkbox"/> Single
<input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander		<input type="checkbox"/> No	<input type="checkbox"/> Moderate		<input type="checkbox"/> Moderate		<input type="checkbox"/> Married
<input type="checkbox"/> White <input type="checkbox"/> Bi or Multi-Racial			<input type="checkbox"/> Proficient		<input type="checkbox"/> Proficient		<input type="checkbox"/> Separated/ Divorced
<input type="checkbox"/> Other							<input type="checkbox"/> Living Together
Highest Grade Completed:			Employment Status:			Relationship to Child:	
<input type="checkbox"/> Grade 8 or below <input type="checkbox"/> High school Grad <input type="checkbox"/> GED			<input type="checkbox"/> Retired <input type="checkbox"/> Seasonal			<input type="checkbox"/> Biological, Adopted, Stepchild	
<input type="checkbox"/> Grade 9 <input type="checkbox"/> Some College/Technical			<input type="checkbox"/> Disabled <input type="checkbox"/> School/ Training			<input type="checkbox"/> Grandchild	
<input type="checkbox"/> Grade 10 <input type="checkbox"/> Technical Certificate			<input type="checkbox"/> Part Time <input type="checkbox"/> Full Time			<input type="checkbox"/> Niece/Nephew	
<input type="checkbox"/> Grade 11 <input type="checkbox"/> Associate's			<input type="checkbox"/> Unemployed (6 months or less)			<input type="checkbox"/> Foster	
<input type="checkbox"/> Grade 12 (non grad) <input type="checkbox"/> Master			<input type="checkbox"/> Unemployed (7 months or more)			<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"/> 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"/> 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"/> 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"/> 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"/> 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:	Whose:	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	<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	<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** *The following questions are to provide the best services possible for your child.*

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

**Central Office Staff Use ONLY**

Date:  In person interview  Phone Interview Staff Initials: \_\_\_\_\_

Application complete?  Yes  No \*If no is checked, mark what info is needed below

Info Needed  Income  BC  Shot record  Insurance Card  Disability Info

Other \_\_\_\_\_

Completed Application Date: \_\_\_\_\_

Accepted  Wait List  Enrolled

Over Income  2 year old  Other note

ChildPlus ID# \_\_\_\_\_

Application entered by: \_\_\_\_\_

Date: \_\_\_\_\_