# Marin Head Start Application for Wait List

**359 Bel Marin Keys Blvd, Suite 1 Novato, CA 94949 415-883-3791 Fax 415-883-6088**
**child@marinheadstart.org**

**Child's Name**______________________________________________________Date of Birth_____________Gender__________

Primary language spoken _____________________________ Other language(s) ________________ Race/Ethnicity_______________

Does your child have a diagnosed disability or special need? ____ If yes, what is the diagnosis? _______________________________

What provider/ agency are you working with around your child's special needs? ____________________________________________

**Parent/Guardian**______________________________Date of Birth______________Gender____ Relationship to child___________

Primary language spoken ______________________ Other language(s)_________________ Race/Ethnicity___________________

Lives with child: ____Yes ____No if no, please list other address ____________________________________________________

**Parent/Guardian**______________________________Date of Birth______________Gender______ Relationship to child_________

Primary language spoken ______________________ Other language(s) _________________ Race/Ethnicity___________________

Lives with child: ____Yes ____No if no, please list other address ____________________________________________________

**Address**________________________________________________________City__________________Zip Code______________

**Phone Numbers**: Home_________________________Work___________________________Cell_________________________

What number do we call first? ______________________

**Child lives with**: One parent ____ Two parent's _____ other adult? ___________________________________________

Number of people in your immediate family? ___________ / How many people living in the home? ___________

**What is your family's total monthly income before taxes? _____________**

**Source of income** ( ✔ all that apply)

Work______ TANF_____ Cal Works_____ SSI______ Other___________

**Is your child receiving WIC?**

___ yes ____ no

**List your child's siblings that live in the home.**

| Name of sibling | Male/Female | Date of Birth |
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**<u>All of the above information must be filled in and complete or your application will not be processed.</u>**

Certification: I certify that this information is true. If any part is false my participation in this agency's program may be terminated. I also understand that the information in this application will be held in strict confidence.

Parent/Guardian Signature: ____________________________________________________ Date:________________