

Tableland Early Childhood Programs
535 East Main Street
Somerset, PA 15501
814-445-9628 or 800-452-0148
Fax: 814-445-8924



Somerset Area School District
105 New Centerville Road
Somerset, PA 15501
Phone: (814) 445-6677
Fax: (814) 445-1821

Enrollment Application

Admission is open to all regardless of race, color, national origin, sex, age, or disability.

Child Information

Child's Name: First _____ Last _____ M _____

Sex: M/F Birthdate: _____ Age: _____ Race (optional) _____ Hispanic/Latino (optional) Y / N

Child resides with: **Mother** **Father** **Stepmother** **Stepfather** **Live In** **Grandmother** **Grandfather** **Foster parents** **Other:** _____

Adult's Name First _____ Last _____ Relationship to Child _____

Birthdate: _____ Marital Status _____ Race (optional) _____ Hispanic/Latino (optional) Y / N

Sex: M / F **If female**-are you pregnant: No/ Yes- Due date: _____

Check **Highest** Education Level Completed:

_____ Did not graduate HS _____ Last grade completed in High School _____ High School Grad or GED
_____ Some College or Certification _____ College Degree

Check Employment Status: Full-time Part-time Unemployed Retired Disabled Student Occupation: _____

Adult's Name First _____ Last _____ Relationship to Child _____

Birthdate: _____ Marital Status _____ Race (optional) _____ Hispanic/Latino (optional) Y / N

Sex: M / F **If female**-are you pregnant: No/ Yes- Due date: _____

Check **Highest** Education Level Completed:

_____ Did not graduate HS _____ Last grade completed in High School _____ High School Grad or GED
_____ Some College or Certification _____ College Degree

Check Employment Status: Full-time Part-time Unemployed Retired Disabled Student Occupation: _____

Child's Natural/Biological Parent's Name if not listed above:

Primary Address of Family

Address: _____ City _____ State: _____ Zip: _____

Primary Phone: _____ Home/Cell -Texting Allowed? Yes / No Email: _____

Phone: _____ Home/Cell -Texting Allowed? Yes / No

Specific Location (directions to your child's home): _____

Household Information

List other children in household first & last name:

Name: _____ Birth Date _____

Name: _____ Birth Date _____

Name: _____ Birth Date _____

Name: _____ Birth Date _____

Emergency Numbers (other than your home or cell) *Required

Name: _____ Relationship _____ Phone: _____

Name: _____ Relationship _____ Phone: _____

Other Information											
Does your child have a documented disability, a special need/concern, a delay, is being or has been seen by a specialist (doctor, therapist, etc.) for any reason?											
Doctor/Specialist		Therapist		IU-08		Early Intervention		Easter Seals		TSS/BSC	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Was this a "high risk" pregnancy or any problems at birth? (mom or child) If yes, explain:								Yes	No		
Was the child premature?								Yes	No		
Did the child have a low birth weight?								Yes	No		
Is the child being raised by someone other than natural parent?								Yes	No		
Are there documented postpartum/depression issues?								Yes	No		
Is this your first child?								Yes	No		
Was the child referred to our program? If yes, by whom: _____								Yes	No		
Is this child currently enrolled in Early Head Start?								Yes	No		
Is this a foster child?								Yes	No		
Is a natural parent in jail/prison?								Yes	No		
Do you have 3 or more children under age of 5								Yes	No		
Please answer yes or no to the following income types that have applied to your family in the past year.											
Cash Assistance								Yes	No		
Food Stamps: (last 4 digits) _____								Yes	No		
Medical Assistance								Yes	No		
Receiving services from CYS								Yes	No		
Receiving WIC								Yes	No		
Substance/Drug Abuse								Yes	No		
IEP/IFSP								Yes	No		
Homeless								Yes	No		
SSI								Yes	No		
Military deployment								Yes	No		
Domestic violence								Yes	No		
Teen mother								Yes	No		
Loss of employment								Yes	No		
Bankruptcy								Yes	No		
Death of an immediate family member								Yes	No		
Major illness or accident								Yes	No		
Head Start /Pre-K Children only											
In what school district do you currently reside:											
If my child is enrolled: (Limited transportation offered) check those that apply											
<input type="checkbox"/> I have no transportation											
<input type="checkbox"/> I can transport to and from the center if needed											
<input type="checkbox"/> I can meet the bus at a designated stop for pick up/drop off.											
<input type="checkbox"/> He/she will also attend a day care or sitter. Where & When _____											

How did you hear about our program? _____

If parents do not live together is there a legal custody order (signed by a judge) in place? Yes No
If yes, please provide a copy.

Parent's or Guardian's Signature: _____	Date _____
Verifying Early Childhood Education Staff's Signature: _____	Date: _____

Income Verification

Source of income: Check those that apply to your family situation in _____ (year) or prior 12 months. Submit proof of your checked "yes" boxes for the total gross amount. **Applications cannot be processed without your income verification.**

Child's Name: _____		# of people in family _____	# of people in household _____
Check all that apply & fill in amount			Totals
Yes	No	1040 Federal income tax for _____ <small>(circle one) Filed Jointly Filed Single</small>	Total gross amount for yr. \$ _____
Yes	No	W-2 forms for all employment in _____ (year) (if income tax form not available)	Father's gross earnings \$ _____ Mother's gross earnings \$ _____
Yes	No	Supplemental Security Income (SSI)	For whom _____ \$ _____ Monthly Amt.
Yes	No	Cash Assistance	For whom _____ What months _____ \$ _____ Amount.
Yes	No	Foster child care rate	\$ _____ For whom _____ Daily rate
Yes	No	Social Security	For whom _____ \$ _____ Monthly Amt.
Yes	No	Social Security Disability (SSD)	For whom _____ \$ _____ Monthly Amt.
Yes	No	Child Support Received	For whom _____ \$ _____ Monthly Amt.
Yes	No	Wages/paystubs	Total gross amount for 12 months \$ _____
Yes	No	Pension	\$ _____ For whom _____ Monthly Amount
Yes	No	Workman's Compensation	\$ _____ Weekly/yearly amount When to when
Yes	No	Unemployment Compensation	For whom _____ \$ _____ Monthly Amt.
Yes	No	Veterans Benefits	For whom _____ \$ _____ Monthly Amt.
Yes	No	Military Benefits	For whom _____ \$ _____ Monthly Amt.
Yes	No	Any Grants/Scholarship for Continuing Education <small>(amount of post high school training money for _____ (year))</small>	\$ _____
Yes	No	Any other source of income <small>(trust fund, settlement, rental property, winnings, interest on bank account etc.)</small>	\$ _____
Yes	No	Do you pay Child Support? Proof needed	For whom _____ \$ _____ Monthly Amt.

This total gross income for _____ (year) or a 12 month period is _____

This income was earned from: (month/yr) _____ to _____ (month/yr)

I certify that this information is true. I also understand that the information in this application will be held in strict confidence & may be shared with other departments within Tableland. Failure to be truthful in verification could result in disqualification of application or dismissal of employee.

Parent's or Guardian's Signature: _____ Date: _____

Verifying Early Childhood Programs Staff's Signature: _____ Date: _____