HVP ENROLLMENT APPLICATION

Parent/guardian's First Name	Middle Initial	Last	Parent/guardian DOB (mm/dd/yyyy)

Education level	Employed? N/A P/T F/T	School/Training? N/A P/T F/T

Latino ☐ Yes ☐ No Race _____	Primary Language	Secondary Language

1 Child's Name	Latino? Yes ☐ No ☐ Race	Child's DOB	Primary Language	Secondary Language
2 Second Child's Name	**Latino? Yes ☐ No ☐ Race**	**Child's DOB**	**Primary Language**	**Secondary Language**

Residential Address			Mailing Address (if different from Residential Address)		
City	State CA	Zip Code	City	State	Zip Code

Primary Phone Number (including area code) Home ☐ Cell ☐	Other Phone (including area code) Home ☐ Work ☐ Cell ☐ Message ☐

Total in Family _____	Ok to text? YES ☐ NO ☐	Ok to email? YES ☐ NO ☐	Email Address:

Current Housing: ☐Rent ☐Own ☐ Homeless

ELIGIBILITY INFORMATION

Family Receives:	Check one if applicable:	Does Family Have Medical Insurance?
SSI YES ☐ NO ☐ TANF/CalWORKs YES ☐ NO ☐	☐Medi-Cal ☐IEHP ☐Healthy Families ☐Emergency ☐ Other	☐Yes ☐No
Does family receive WIC? ☐Yes ☐No	**Does Family Receive CalFRESH (EBT)?** ☐Yes ☐No	**Does Child Have Dental Insurance?** ☐Yes ☐No

PRENATAL INFORMATION

☐ **N/A** ☐ **Pregnant before Enrollment** ☐ **First Pregnancy** **Expected delivery date:** _____

Your disclosure of this information is strictly voluntary.

1. Does your child have a disability? _____ (If no, please go to question #6)
2. Type of special need or disability _____
3. Has the disability been professionally diagnosed? (If yes, at what age _____? By whom? _____
4. Does the child have an IFSP/IEP? _____
5. Is the child receiving special services for the disability? _____
6. In your opinion, does your child have a special need that has not yet been diagnosed? If yes, please explain:

Applicant Signature :_____ **Date:**_____

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 within the agency and is accessible to me during normal business hours.

COUNTY USE ONLY

HVP Start Date	TAD Office:	C-IV ID:	ChildPlus Individual ID: ChildPlus Family ID:

Staff Signature: **Print Name** **Date:**