



**COMMUNITY ACTION COMMISSION  
OF SANTA BARBARA COUNTY  
EARLY HEAD START PROGRAM**



201 WEST CHAPEL STREET  
SANTA MARIA, CA 93458  
(800) 894-0160 or 922-2243

120 WEST CHESTNUT AVENUE  
LOMPOC, CA 93436  
(805) 740-4555

Revised March 2012  
5681 HOLLISTER AVENUE  
GOLETA, CA 93117  
(805) 964-2347

## PREGNANT WOMEN PROGRAM

APPLICATION INFORMATION										
MOTHER'S NAME				DATE OF BIRTH	AGE	LANGUAGE				
						<input type="checkbox"/> ENGLISH	<input type="checkbox"/> SPANISH	<input type="checkbox"/> OTHER		
HOME ADDRESS				CITY, STATE, ZIP CODE			HOME TELEPHONE NUMBER			
MAILING ADDRESS (IF DIFFERENT THAN ABOVE)				CITY, STATE, ZIP CODE			MESSAGE TELEPHONE NUMBER			
MARITAL STATUS		IF MINOR, WHO DO YOU LIVE WITH?								
		<input type="checkbox"/> Mother		<input type="checkbox"/> Father		<input type="checkbox"/> Guardian		<input type="checkbox"/> Homeless		<input type="checkbox"/> Other: _____
ARE YOU: (CHECK ANY THAT APPLY)										
<input type="checkbox"/> Student FT / PT		Education Level _____			<input type="checkbox"/> Employed		<input type="checkbox"/> Seeking Employment			
FATHER'S NAME				DATE OF BIRTH	AGE	LANGUAGE				
						<input type="checkbox"/> ENGLISH	<input type="checkbox"/> SPANISH	<input type="checkbox"/> OTHER		
HOME ADDRESS				CITY, STATE, ZIP CODE			HOME TELEPHONE NUMBER			
ARE YOU: (CHECK ANY THAT APPLY)										
<input type="checkbox"/> Student FT / PT		Education Level _____			<input type="checkbox"/> Employed		<input type="checkbox"/> Seeking Employment			
ARE YOU A CAC EMPLOYEE?		ARE YOU A RELATIVE OF CAC EMPLOYEE?			IF YES, NAME OF EMPLOYEE:					
YES	NO	YES	NO							
OTHER SIBLINGS IN THE HOUSEHOLD (use back of this application for additional names)										
NAME			DATE OF BIRTH	NAME			DATE OF BIRTH			
RELATIONSHIP				RELATIONSHIP						
NAME			DATE OF BIRTH	NAME			DATE OF BIRTH			
RELATIONSHIP				RELATIONSHIP						
HOUSEHOLD INFORMATION										
IS EITHER PARENT IN THE U.S. MILITARY?		DO YOU RECEIVE PUBLIC ASSISTANCE (TANF, SSI)			DO YOU RECEIVE WIC?		DO YOU RECIEVE FOOD STAMPS?			
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
WERE YOU REFERRED TO OUR AGENCY?		NAME OF REFERRING AGENCY:			ARE YOU A TAPP CLIENT?					
Yes	No				Yes	No				
AGENCIES YOU CURRENTLY RECEIVE SERVICES FROM:										
LIST ANY OTHER AGENCIES YOU'VE RECEIVED SERVICES FROM:										
OTHER INFORMATION										
MAY WE CONTACT YOU AT HOME?		IF NO, WHERE CAN WE REACH YOU?			ARE YOU A FIRST TIME PARENT?		WHEN IS YOUR DUE DATE?			
Yes	No				Yes	No				
DO YOU HAVE ANY CONCERNS ABOUT YOUR PREGNANCY OR ANY OTHER SITUATION THAT WOULD HELP US TO BETTER SERVE YOU?										
<hr/> <hr/>										
<p><b>I CERTIFY, UNDER PENALTY OF PERJURY, THAT THE ABOVE INFORMATION AND THE DOCUMENTS I HAVE PROVIDED WITH THIS APPLICATION CONCERNING MY ELIGIBILITY ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.</b></p>										
Applicant's Signature: _____						Date: _____				
<b>FOR OFFICE USE ONLY</b>										
<input type="checkbox"/> Verification of Income		<input type="checkbox"/> Verification of Pregnancy			Date Application Received:					
<input type="checkbox"/> Verification of Parental Status		<input type="checkbox"/> Release for Eligibility (if applies)								
<input type="checkbox"/> Verification of Homelessness		<input type="checkbox"/> Documentation of CWS			Date of Application Complete and Verified:					
Enrollment Staff Name: _____										

