



**YES!! CONTACT ME TO
TELL ME MORE ABOUT HEAD START**

Parent/Guardian Name: _____

Child Name _____ DOB _____

Address _____

City/Zip Code _____

Home Phone # _____ Cell # _____

Family Size _____ How did you hear about Head Start? _____

Current Source of Income (Check all that apply)

_____ FIP (Welfare Cash Benefits) _____ Foster Child Payments
_____ Wages _____ SSI (Disability Benefits)
_____ Other (Please specify) _____

What program options are you interested in learning more about? (Check all that apply)

_____ Head Start part day/school year program (3 to 5 year old)
_____ Head Start year round child care program (3 to 5 year old)
_____ Early Head Start year round child care program (8 wks to 3 year old.)
_____ Early Head Start home based program (pregnant women to 3 year old.)

Your signature below authorizes us to contact you with information about the program.

Parent/Guardian Signature _____ Date

Please forward to Debby Coofer, Enrollment Manager

Mail to: 8 John H Chafee Blvd.
Newport, RI 02840
Fax to: (401) 367-2009
Or call: 1-877-367-2008 ext 206 for more information

EBCAP Head Start will assist families to understand and access transportation options through the following services:

- **Provision of information about RIPTA bus passes, routes and other services.**
- **Individual assistance with transportation issues such as flexible scheduling and alternative site placements.**

1-877-367 2008
www.ebcap.org