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)

_________Wages

_________Other (Please specify)____

________Foster Child Payments

________SSI (Disability Benefits)

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