

EICAP Head Start Mini-Application

Child
Name: _____

Date of
birth: _____

Gender: () female () male

Living address: _____

Phone
Number: _____

Parents or Guardian Name:

Number of family members _____

Annual Income \$ _____

Please check if any of the following apply:

- () *TANF* () *SSI*
() *Homeless Shelter*
() *Identified Disability*
() *Suspected Disability*

Please return completed Mini-Application
to address listed below

**EICAP Head Start
P. O Box 51098
Idaho Falls, Idaho
83405**

**Phone: 208-522--5370 ex. 1067
Fax: 208-542-1453
E-mail: hsinfo@eicap.org
Website: www.eicap.org**