Honolulu Community Action Program, Inc.
Head Start Program
33 South King Street, Suite 300
Honolulu, Hawaii 96813
Phone #: 847-2400

Intake Application

Please type or print all the information to prevent the delay in processing the application.
All information will be held in strict confidence.

Child's Information

First Name: ___________________ Initial: ______ Last Name: __________________________

Date of Birth: ___________________ Gender: ○ Male ○ Female

Parent/Guardian Information

First Name: ___________________ Initial: ______ Last Name: __________________________

Date of Birth: ___________________ Gender: ○ Male ○ Female

Relationship to the Child: ____________________________

Living Address: ____

City: ____________________ State: Hawaii Zip Code: ________________

Mailing Address: ____

City: ____________________ State: Hawaii Zip Code: ________________

Home Phone: _____________ Work Phone: __________________ Other Phone: __________________

Additional Contact Information

Other Contact Person's Name: ____

Other Contact Person's Daytime Phone: ____________________

For Head Start office use only: School Year: ______/______
Date Received: ________________ Center: ________________
Center Control: ________________ Data Entry: ____________

SECTION: Intake

Fill out this section for all family members, excluding the child and the parent/guardian listed on the front page.

Other Family Member Name(s) (First, Middle Initial, Last)	Date of Birth (MM/DD/YY)	Gender M/F	Relationship to the Applying Child
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Number of adults in your family: _______

Number of children in your family: _______

How did you hear about us?

- ☐ Bus Ad
- ☐ Community Fair
- ☐ Flyer
- ☐ Head Start Classroom
- ☐ Mail
- ☐ Other: __________

Applicant Certification and Signature

I certify that the information provided in support of this application is accurate and truthful to the best of my knowledge.

Parent/Guardian's Signature: ______________________________ Date: ____/____/____

Fill out the following if you are an agency referring the family to the HCAP Head Start program.

Agency/Office: ____

Representative's Name: ______________________________ Phone: ______________

Representative's Signature: ____________________________ Date: ____/____/____

Make sure all information is accurate and complete. Please sign and date, then send in this form by mail or fax.

Mail to: Honolulu Community Action Program, Inc.
Head Start Program
33 South King Street, Suite #300
Honolulu, HI 96813

Fax to: 847-2302

HCAP does not discriminate on the basis of religion, sex, race, color, national origin, or persons with disabilities.