

KIRYAS JOEL MUNICIPAL LOCAL DEVELOPMENT CORP.

HEAD START PROGRAM

7 Israel Zupnick Dr. * Monroe, NY 10950 * (845) 783-0990 Fax: (888) 300-3126

Pre-Registration 2026-2027

Dear Parents,

Thank you for your interest in sending your child to the KJMLDC Head Start Program.

Please be aware that Head Start programs are supposed to enroll children from families who fall beneath the Federal Poverty Guidelines, or are receiving TANF, SSI, or SNAP. The Federal Poverty Guidelines for 2026 are these ratios of **family size** to income:

<u>Family Size:</u>	<u>Income:</u>	<u>Family Size:</u>	<u>Income:</u>
3.	\$27,320	9.	\$61,400
4.	\$33,000	10.	\$67,080
5.	\$38,680	11.	\$72,760
6.	\$44,360	12.	\$78,440
7.	\$50,040	13.	\$84,120
8.	\$55,720	14.	\$89,800

In addition to filling out this application completely, you will need to attach copies of the following documents to be considered for our program.

1. **PROOF OF INCOME** - 2025 Tax 1040 form or 2024 W2 form. If you are a TANF, SSI, or SNAP recipient, only the letter of approval is needed.
2. A copy of your child's **BIRTH CERTIFICATE**.
3. A copy of your child's **IMMUNIZATION RECORD**. In order for your child to start school, he/she must be up to date with **physicals, dental visits, and immunizations**. Please schedule your appointments now.
4. **PROOF OF ADDRESS** – A copy of a utility bill.
5. If your child is receiving services from the KJ Public School, please send along a copy of his/her IEP for School Year 2026-2027.

Please note: We will need Proof of Income, Birth Certificate, Immunizations and Proof of Address in order to be accepted.

There will be NO EXCEPTIONS!!

Applications may be returned by:

Mail - 7 Israel Zupnick Dr., Monroe, NY 10950

Fax - 888-300-3126

The Head Start Staff

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Pre-Registration Form

School Year
2026-2027

Child's Name: _____

Date of Birth _____

Address: _____ Unit # _____

Doctor's Name: _____

Dentist Name: _____

Phone #: _____

Hospital Preference: _____

Father's Name: _____

Mother's Name _____

Occupation: _____

Occupation: _____

Employer's Name: _____

Employer's Name: _____

Address: _____

Address: _____

Phone #: _____

Phone #: _____

Date of Birth _____

Date of Birth _____

Do you receive:

Food Stamps Yes____ No____

Welfare Yes____ No____

Wic Yes____ No____

Section 8 Yes____ No____

Do you have medical insurance? _____

Medicaid or Private

Is your child receiving any services from the KJ Public School or other sources? _____

If Yes, Explain: _____

Please provide IEP for the 2026-2027 School Year.

Do you think your child needs special services (ex. Speech, OT, PT, etc.)? _____

Does your child have any severe allergies? _____ If yes, please provide proof

Number of children in household _____

Parents Signature: _____

Date: _____

