ICCC HEAD START APPLICATION
2018-2019

OFFICE USE
100%____100-130%____OI____
Face to Face Int. by:_____
Phone Int. by:_____

The information given is confidential. You are not required to provide this information, however, incomplete or inaccurate information may prevent us from determining your eligibility for the Head Start program. If you need assistance completing the application, please call **1-888-778-4008.**

Applicant #1:

(OFFICE USE: Priority #_____)

Child's First Name:	Middle Name:	Child's Last Name:	Date of Birth ____/____/____	☐ Male ☐ Female
Child's Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black ☐ White ☐ Multi-Racial ☐ Other_____ Hispanic ☐ Yes ☐ No		Language Spoken at Home ☐ English ☐ Other:_____	Child is on an IEP or IFSP (They receive special ed. services) ☐ Yes ☐ No	
Child has a diagnosed Medical Condition: ☐ Yes ☐ No Child has known allergies: ☐ Yes ☐ No If yes, explain:				

Do you have any developmental concerns for the child listed above? ☐ Yes ☐ No

If yes, explain:

Applicant #2:

(OFFICE USE: Priority #_____)

Child's First Name:	Middle Name:	Child's Last Name:	Date of Birth ____/____/____	☐ Male ☐ Female
Child's Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black ☐ White ☐ Multi-Racial ☐ Other_____ Hispanic ☐ Yes ☐ No		Language Spoken at Home ☐ English ☐ Other:_____	Child is on an IEP or IFSP (They receive special ed. services) ☐ Yes ☐ No	
Child has a diagnosed Medical Condition: ☐ Yes ☐ No Child has known allergies: ☐ Yes ☐ No If yes, explain:				

Do you have any developmental concerns for the child listed above? ☐ Yes ☐ No

If yes, explain:

Address:

Living Address (include apt, unit, etc)	Zip Code	City
Mailing Address (if different from Living Address)	Zip Code	City

Directions to your home	County	School District

Parent / Guardian Information

Parent/Guardian 1: First Name	Last Name	Date of Birth ____/____/____	☐ Male ☐ Female	Lives with Child? ☐ Yes ☐ No

Parent's Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black ☐ White ☐ Multi-Racial ☐ Other_____ Hispanic ☐ Yes ☐ No	Relationship to Child: ☐ Mother ☐ Father ☐Legal Guardian o Foster Parent o Court Ordered o Parent Appointed ☐ Other_____	Employment Status ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Student ☐ Self-Employed ☐ Unemployed ☐ Stay at home parent ☐ Retired/Disabled
Parent's Primary Language: ☐ English ☐ Other_____		
Parent is a veteran? ☐ Yes ☐ No Parent is a member of the military? ☐ Yes ☐ No	Place of Work:_____ Work Phone:_____	
Preferred Contact Method: ☐ Phone Call #_____ ☐ Text #_____ ☐ Email_____	Parent Education Level: ☐ High School-Not Graduated ☐ 2 Year Degree ☐ High School-Graduated ☐ 4 Year Degree ☐ GED ☐ Master's Degree	

Parent/Guardian 2: First Name	Last Name	Date of Birth ____/____/____	☐ Male ☐ Female	Lives with Child? ☐ Yes ☐ No

Parent's Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black ☐ White ☐ Multi-Racial ☐ Other_____ Hispanic ☐ Yes ☐ No	Relationship to Child: ☐ Mother ☐ Father ☐Legal Guardian o Foster Parent o Court Ordered o Parent Appointed ☐ Other_____	Employment Status ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Student ☐ Self-Employed ☐ Unemployed ☐ Stay at home parent ☐ Retired/Disabled
Parent's Primary Language: ☐ English ☐ Other_____		
Parent is a veteran? ☐ Yes ☐ No Parent is a member of the military? ☐ Yes ☐ No	Place of Work:_____ Work Phone:_____	
Preferred Contact Method: ☐ Phone Call #_____ ☐ Text #_____ ☐ Email_____	Parent Education Level: ☐ High School-Not Graduated ☐ 2 Year Degree ☐ High School-Graduated ☐ 4 Year Degree ☐ GED ☐ Master's Degree	

List any other people living in the home not already listed above

First Name	Last Name	Relationship to Child	Date of Birth	Gender	Race	Hispanic/ Latino
				☐ Male ☐ Female		☐ Yes ☐ No
				☐ Male ☐ Female		☐ Yes ☐ No
				☐ Male ☐ Female		☐ Yes ☐ No
				☐ Male ☐ Female		☐ Yes ☐ No
				☐ Male ☐ Female		☐ Yes ☐ No

In an effort to best serve your child / family, please check any of the following conditions that currently affect or have affected the child's household. **The information given is confidential. You are not required to provide this information, though it may be helpful in providing the best services to your family.**

Environmental Factors
("X" all that apply)

☐ Household member with disability or health condition
☐ Domestic Violence: Current or past issues
☐ Parent substance abuse
☐ Documented or suspected child abuse: Current or past issues
☐ Parent incarceration (within last 2 years)
☐ Household member with mental health issues
☐ Death of Immediate Family Member
☐ Do you feel you have a lack of social support system
☐ You have been homeless in last 12 months
☐ Decrease in family income
☐ Other:_____
☐ None of the above

Because Head Start receives funding from the Department of Health and Human Services, **we must ask for income information and ask that it be verified.** Total gross income for 2017 or the past 12 months must be included.

Sources of Household Income and Other Assistance
("X" all that apply)

☐ Salary or Wages*
☐ Child Support Received*
☐ MFIP or DWP*
☐ Self Employment *
☐ SSI/Disability*
☐ Unemployment Comp.*
☐ Social Security*
☐ Veteran's Benefits*
☐ Retirement/Pension*
☐ Interest/Other*
☐ No Income – Explain:_____
_____

☐ Energy Assistance
☐ Food Support
☐ Housing/HUD
☐ Subsidized Childcare
☐ Medical Assistance
☐ WIC

* indicates it needs to be verified.

PLEASE ATTACH INCOME DOCUMENTATION!

If you are unable to provide your income information with the application, please complete the section below and we will attempt to collect the information for you. Please be specific on where to request the information from. All income information will be kept confidential.

ICCC Head Start has permission to request income information from:

☐ Employer(s) _____
Name of Employer Address

_____
Name of Employer Address

☐ Social Services (for MFIP/cash assistance only):_____
County

☐ Social Services (for foster placement):_____
County

☐ Tax Preparer:_____
Name of Preparer Address

☐ Child Support Services:_____
County

☐ Other:_____

We are unable to obtain information from the Social Security Administration, Jackson Hewitt Tax Service, Walmart, Sanford Health or the Workforce Center for Unemployment Benefits. (This information will need to be provided by you).

To the best of my knowledge, the information I have given in the application is accurate and true.
ICCC has permission to request and receive information with the above identified agencies/businesses/ organizations regarding income documentation. I understand that ICCC Head Start may share the data included with this application (including income) with other programs / services provided by Inter-County Community Council. **If ICCC will be requesting income for both parents/guardian, both MUST sign below.**

Parent/Guardian Signature_____ Date_____/_____/_____

Parent/Guardian Signature_____ Date_____/_____/_____

Return completed application to:

ICCC Head Start, PO Box 189, Oklee, MN 56742 Fax: 218-796-5175
or Email: headstart@intercountycc.org

Staff Initials:_____

RELEASE OF INFORMATION
(To be completed for each applicant)

Applicant #1:

Child's First Name	Middle Name	Child's Last Name	Date of Birth ____/____/____	☐ Male ☐ Female
Parent Name (First and Last)		Relationship to Child		

To help your child complete the Head Start requirements, ICCC works with area agencies, clinics and providers to get records concerning your child so that completed services and screenings do not have to be repeated.

PLEASE CHECK all agencies that we may contact for records:

☐ **Public School** - For Early Childhood screening results, IEP, IFSP, program registration

Name of School District_____

☐ **Medical Provider – Entire medical record including but not limited to:**
well child check/physical exams, lab results, MN Risk Assessment, hearing and vision screening, immunizations, referrals, follow up treatment, dental exam results, height, weight, vitals, allergies

Name of Clinic_____City_____

☐ **WIC** - For hemoglobin, lead screen, nutrition assessment, recommendations

By signing this release you are stating the following:

- **This authorization is valid for existing records and those created after the date of signature/authorization.**
- I understand that the information to be accessed and/or exchanged regarding my child/family will be treated as private data under the Minnesota Government Data Practices Act, FERPA, and/or IDEA. This means that the information will be safeguarded as required by law. Information may be released/accessed/exchanged without my further signed consent unless I should revoke my consent.
- I understand that is information is being shared to meet program performance standards/requirements, to plan comprehensive services and coordinate service delivery.
- I AUTHORIZE ICCC Head Start to request, receive, and exchange individually identifiable information with the above agencies/entities that have information concerning my child/family, including written and verbal exchanges. I understand that the information by this consent cannot be released to anyone other than those listed above unless I give written permission. **I understand that I may revoke this consent in writing at any time,** except to the extent that action has already been taken in reliance on it, and that **the consent will automatically expire 24 months from the date of my signature.** I understand that once information is released pursuant to this authorization, the provider cannot present the re-disclosure of that information as it is no longer protected by federal privacy regulations. A photocopy or fax of this authorization will be treated in the same manner as the original. I understand that treatment, payment, enrollment or eligibility of benefits by a covered entity may not be conditioned on obtaining the individual authorization.

Parent/Guardian Signature_____

Date _____/_____/_____

If applying for more than one child, please complete next page.

RELEASE OF INFORMATION
(To be completed for each applicant)

Applicant #2:

Child's First Name	Middle Name	Child's Last Name	Date of Birth ____/____/____	☐ Male ☐ Female
Parent Name (First and Last)		Relationship to Child		

To help your child complete the Head Start requirements, ICCC works with area agencies, clinics and providers to get records concerning your child so that completed services and screenings do not have to be repeated.

PLEASE CHECK all agencies that we may contact for records:

☐ **Public School** - For Early Childhood screening results, IEP, IFSP, program registration

Name of School District_____

☐ **Medical Provider – Entire medical record including but not limited to:**
well child check/physical exams, lab results, MN Risk Assessment, hearing and vision screening, immunizations, referrals, follow up treatment, dental exam results, height, weight, vitals, allergies

Name of Clinic_____City_____

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Parent/Guardian Signature_____

Date _____/_____/_____