
# 2017-18 Head Start Application
# Inter-County Community Council

PO Box 189, Oklee, MN 56742
www.intercountycc.org headstart@intercountycc.org

**Head Start is a preschool program for income eligible children and their families ages birth to five in Clearwater, Pennington, East Polk and Clearwater Counties. The Head Start program is provided at no charge to you. The program focuses on education, health, mental health, nutrition and family services. All information on this application will be kept confidential.**

## CHECKLIST FOR COMPLETING THE APPLICATION

If you need assistance, please call the main office at 888-778-4008.

☐ Complete and sign the entire application
☐ Provide proof of income.
- 2016 Federal Tax Form 1040 (*the page showing adjusted gross income is needed)*
- OR – copies of all the following you receive:

  - Paystubs – for the last 12 months
  - Child support – court statement or something showing monthly amount received
  - Unemployment benefits – printout
  - SSI - award letter or bank statement
  - Grants or scholarships
  - MFIP – printout from the county
  - Social Security Benefits – award letter or bank statement
  - Any other income not listed above
- OR – if you currently do not have income, please request a "*Declaration of No Income"* form.

☐ Foster Care or Guardianship
- Provide documentation of Foster Placement or Guardianship.

When the required information has been provided the application will be processed and you will be notified of your child's status with Head Start. The application will be valid for the current school year. Please let us know if your address or telephone number change so we can update your child's application.

## PROGRAM OPTIONS DESCRIPTIONS

- **Home Based Option -** The home based option is available for ages birth to five in all communities in our service area. A Home Visitor will come to your home each week and provide ways for you to help your child learn and grow.
- **Combination Option –** The Combination Option is currently available for 4 year old children in Fosston, Oklee and Win-E-Mac school districts. Children will go to a classroom 2-3 days a week. Families receive home visits as part of this option.
- **Center Based Option -** The Center Based option is available for 4 year olds in Bagley and Thief River Falls. Children will go to a classroom 4 days a week. Parents receive scheduled home visits as part of this option.

Family Events are offered for all the program options.

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# HEAD START APPLICATION 2017-2018

OFFICE USE
Priority #_____
100%_____ 100-130%_____ OI _____
Face to Face Interview by:_____
Phone Interview by:_____

**Please fill out entire application, please print clearly**

## SECTION 1. FAMILY INFORMATION

| **Child's First Name** | **Middle Name** | **Child's Last Name** | **Date of Birth** ____/____/____ | ☐ Male ☐ Female |
|---|---|---|---|---|

What do you consider your child's race?
☐American Indian/Alaskan Native
☐Asian ☐Black/African American ☐Native Hawaiian/Pacific Islander
☐White ☐Multi-Racial/Bi-Racial ☐Other:_____
Do you consider your child's ethnicity to be Latino or Hispanic?
☐Yes ☐No

Child's Home/First Language
☐ English ☐Other_____

Child's Secondary Language
☐ English ☐ Other_____

How well does your child speak English?
☐Proficient ☐Moderate ☐Poor ☐None

| Child's Home Address (Include apt, unit, etc) | Zip Code | City | State |
|---|---|---|---|
| Mailing Address (**if different than home address**)(Include apt, unit, etc) | Zip Code | City | State |

Write out directions to your home:

County:_____

School District:_____

**Family Status:**
☐Two Parent Family ☐Single Parent ☐Single Parent Living with Partner ☐Legal Guardian
☐Foster Family (please include letter with proof of placement) ☐Grandparent Raising Grandchildren ☐ Other_____

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

Parent's/Guardian's Race
☐American Indian/Alaskan Native
☐Asian ☐Black/African American
☐Native Hawaiian/Pacific Islander
☐White ☐Multi-Racial/Bi-Racial
☐Other:_____
Is this parent/guardian Hispanic or Latino?
☐ Yes ☐ No

Relationship to Child (check one below)
☐Mother
☐Father
☐Legal Guardian (check one)
- °Foster Parent
- °Court Ordered
- °Parent Appointed

☐Other_____

Employment Status
(Check all that apply in the last 12 months)
☐Full-Time ☐Seasonal
☐Part-Time ☐Self-Employed
☐Student ☐Stay-at-home Parent
☐Unemployed ☐Retired/Disabled
If part time # of hrs/wk _____

Parent's/Guardian's Home/First Language
☐ English
☐ Other_____

Parent's/Guardian's Secondary Language
☐ English
☐Other_____

☐Veteran
☐Member of Military

How well does this parent/guardian speak English?
☐Proficient ☐Moderate ☐Poor ☐None

Preferred Written Language:_____

Preferred Contact method: (Include contact information)
☐ **PHONE CALL #**_____
☐ **EMAIL**_____
☐ **TEXT #**_____

Place of work

Work Phone:

Education Level
☐High School-Not graduated ☐High School Grad ☐Credential/Certificate
☐GED ☐2 Yr Degree ☐4 Yr Degree ☐Master's Degree

| **Parent/Guardian 2: First Name** | **Last Name** | **Date of Birth**<br>____/____/____ | ☐ Male<br>☐ Female | Lives with child?<br>☐Yes<br>☐No |
|---|---|---|---|---|

| Parent's/Guardian's Race<br>☐American Indian/Alaskan Native<br>☐Asian ☐Black/African American<br>☐Native Hawaiian/Pacific Islander<br>☐White ☐Multi-Racial/Bi-Racial<br>☐Other:_____<br>Is this parent/guardian Hispanic or Latino?<br>☐ Yes ☐ No | Relationship to Child (check one below)<br>☐Mother<br>☐Father<br>☐Legal Guardian (check one)<br>°Foster Parent<br>°Court Ordered<br>°Parent Appointed<br>☐Other_____ | Employment Status<br>(Check all that apply in the last 12 months)<br>☐Full-Time ☐Seasonal<br>☐Part-Time ☐Self-Employed<br>☐Student ☐Stay-at-home Parent<br>☐Unemployed ☐Retired/Disabled<br>If part time # of hrs/wk _____ |
|---|---|---|
| Parent's/Guardian's Home/First Language<br>☐ English<br>☐ Other_____ | Parent's/Guardian's Secondary Language<br>☐ English<br>☐Other_____ | ☐Veteran<br>☐Member of Military |
| How well does this parent/guardian speak English?<br>☐Proficient ☐Moderate ☐Poor ☐None<br>Preferred Written Language:_____ | Preferred Contact method: (Include contact information)<br>☐ **PHONE CALL #**_____<br>☐ **EMAIL**_____<br>☐ **TEXT #**_____ | |
| Place of work<br>Work Phone: | Education Level<br>☐High School-Not graduated ☐High School Grad ☐Credential/Certificate<br>☐GED ☐2 Yr Degree ☐4 Yr Degree ☐Master's Degree | |

| **LIST ALL OTHER PEOPLE LIVING IN THE HOME:** | | | Total number of family members: | | | |
|---|---|---|---|---|---|---|
| First Name | Last Name | Relationship to child | Date of Birth | Gender | Race | Hispanic/Latino |
| | | | | ☐M ☐F | | ☐Yes ☐No |
| | | | | ☐M ☐F | | ☐Yes ☐No |
| | | | | ☐M ☐F | | ☐Yes ☐No |
| | | | | ☐M ☐F | | ☐Yes ☐No |
| | | | | ☐M ☐F | | ☐Yes ☐No |
| | | | | ☐M ☐F | | ☐Yes ☐No |

## SOURCES OF HOUSEHOLD INCOME AND OTHER ASSISTANCE ("X" all that apply)

| | | | |
|---|---|---|---|
| ☐ Salary or Wages * | ☐ General Assistance * | ☐ Veteran's Benefits * | ☐ Housing/HUD |
| ☐ Child Support Received * | ☐ Unemployment Comp. * | ☐ Retirement/Pension * | ☐ Food Support |
| ☐ MFIP or DWP * | ☐ Social Security * | ☐ Energy Assistance | |
| ☐ Self Employment * | ☐ Interest/Other * | ☐ Subsidized Childcare | |
| ☐ SSI/Disability * | * Please attach income verification if starred * | | |

☐ No Income – Explain:_____ _____

**Are there any family circumstances you would like us to be aware of that may help you qualify?**

# SECTION 2. HEALTH AND WELLNESS

## SUSPECTED DISABILITIES AND SPECIAL NEEDS

**Do you or someone else <u>suspect</u> your child needs support in any of the following areas?** *(If **YES**, please check.)*

☐Attention Deficit Disorder (ADD or ADHD) ☐Hearing Impairment/Deaf ☐Speech Impairment
☐Autism ☐Down's Syndrome ☐Visual Impairment (Including Blindness)
☐Behavioral Concerns ☐Mental Health Diagnosis ☐Other:_____
☐Developmental Delays (cognitive/learning) ☐Orthopedic Impairment (Gross/Fine Motor)

**HAS YOUR CHILD HAD….**

A lead level check? ☐Yes ☐No

A hemoglobin check? ☐Yes ☐No

A Well Child Check (physical exam) within the last year? ☐Yes ☐No

A Dental Exam within the last year? ☐Yes ☐No

Any of the **HEALTH CONCERNS** listed below? (If **YES,** please check)

☐Anemia ☐Failure to Thrive
☐Cerebral Palsy ☐Feeding or Swallowing Issues
☐Child Born Prematurely (more than 4 weeks) ☐Traumatic Head Injury ☐Tuberculosis
☐Diabetes ☐Other, Describe:_____
☐Birth Defect _____
☐Epilepsy/Seizure Disorder/Febrile Seizures
☐High Lead Levels/Lead Exposure/Lead Poisoning
☐ ASTHMA/UPPER RESPIRATORY BREATHING ISSUES

Any **ALLERGIES**? ☐Yes ☐No (If **YES,** please list them below.)
To food? _____
To medication? _____
Other? _____

Any **MEDICATIONS?** (If **YES,** please answer below.)☐Yes ☐No
Which medications? _____

Will your child need to take the medications at school?☐Yes ☐No

A recent history of a **SERIOUS ILLNESS/DISEASE?** ☐Yes ☐No

A recent history of **HOSPITALIZATION?** ☐Yes ☐No

A recent history of **SURGERY?**☐Yes ☐No

A recent history of **BEING SEEN BY A MEDICAL SPECIALIST OR MENTAL HEALTH PROFESSIONAL?** ☐Yes ☐No

If **YES** to any of the above, describe: _____

**DIAGNOSED DISABILITIES AND SPECIAL NEEDS**

Does your child have current/active **IEP or IFSP** (they receive special education services)? ☐Yes ☐No
(If **YES,** please provide a copy of your child's IEP or IFSP.)

Where are the services provided?
☐School ☐Home ☐Child Care ☐Other _____

**ENVIORMENTAL FACTORS (please check all that apply)**

☐Death of immediate family member
☐Documented or suspected child abuse: Current or past issues
☐Domestic violence: Current or past issues
☐Household member with disability
☐Household member with mental health issues
☐Parent(s) with health condition
☐Do you feel you have a lack of a social support system
☐No health insurance for child
☐No health insurance for family
☐Parent incarceration (Recently or within the last 2 years)
☐Parent substance abuse (Alcohol or Chemical Dependency) Current or past issue
☐Parent(s) were younger than 18 at birth of child applicant
☐Single parent family
☐Family was homeless in last 12 months
☐Currently enrolled in Head Start or Early Head Start
☐Previously enrolled in Head Start or Early Head Start
☐Decrease in family income
☐Parent military deployment
☐Other:_____
☐None of the above

## SECTION 3. SIGN AND DATE APPLICATION

## INCOME DOCUMENTATION

Head Start is an income based program. Any family can apply for Head Start, but priority is given to children who meet the income guidelines or have a special need or disability.

## PLEASE ATTACH INCOME INFORMATION!

***(See the cover page for a list of what to attach)***

**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 any information from the Social Security Administration, Jackson Hewitt Tax Service, Walmart, 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 this full application is accurate and true.**

**ICCC has my authorization 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 operated by Inter-County Community Council. **If ICCC will be requesting income for both parents / guardians, both MUST sign below.**

**Signature of Parent/Guardian** _____ Date_____/_____/_____

**Signature of Parent/Guardian** _____ 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_____ 01/2017

# SECTION 4. RELEASE OF INFORMATION

| Child's First Name | Middle Name | Child's Last Name | Date of Birth ___/___/___ | ☐ Male ☐ Female |
|---|---|---|---|---|
| **Parent Name (First & Last)** | | **Relationship to Child** | | |

To help your family complete the Head Start / Early Head Start program requirements, ICCC works with area agencies / clinics / providers to get records concerning your child so that completed services / screenings do not have to be repeated, provide our comprehensive services and coordinate our service delivery.

**PLEASE CHECK all the agencies that we may contact for records:**

| AGENCY | INFORMATION / SERVICES TO BE DISCLOSED |
|---|---|
| _____ _____Public School | Early childhood screening results, IEP, IFSP, program registration |
| _____ Special Education / Special Education Cooperative | Early childhood screening results, IEP, IFSP, program registration |
| _____ _____ County Public Health / Nursing Service | Well child checks, early childhood screening results, hemoglobin, lead screen, WIC, vitals, hearing / vision screening, height, weight |
| _____ WIC | hemoglobin, lead screen, nutrition assessment / recommendations |
| _____ Medical Provider _____ | Well child check / physical exams, lab results, MN Risk Assessment, hearing & vision screening, immunizations, referrals, follow up treatment, dental exam results, height, weight, vitals, allergies |
| _____ Dental Provider _____ | dental exams, treatment plan, treatment received, referrals |
| _____ Indian Health Services | Well child check / physical exams, lab results, MN Risk Assessment, hearing & vision screening, immunizations, referrals, follow up treatment, dental exam results, height, weight, vitals, allergies dental exams, treatment plan, treatment received, referrals |
| _____ Nutritional Consultant | Nutrition assessment, recommendations |
| _____ Mental Health Consultant | Observation notes, referral recommendations, classroom implementation strategies |
| _____ Minnesota Department of Health Lead Screen | lead screen results |
| _____ Inter-County Community Council (other programs) | contact or crisis information for other program services |
| _____ Social Services | social workers / financial workers for streamlining services |
| _____ Other _____ | _____ |
| _____ Other _____ | _____ |

By signing this release below 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 this 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 following agencies / entities that have information concerning my child/family, including written and verbal exchanges. I understand that the information disclosed 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 12 months from the date of my signature**. I understand that once information is released pursuant to this authorization, the provider cannot prevent 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 _____/_____/_____

Staff Initials_____ 01/2017