



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 ____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child's Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other _____ Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No		Language Spoken at Home <input type="checkbox"/> English <input type="checkbox"/> Other: _____	Child is on an IEP or IFSP (They receive special ed. services) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child has a diagnosed Medical Condition: <input type="checkbox"/> Yes <input type="checkbox"/> No Child has known allergies: <input type="checkbox"/> Yes <input type="checkbox"/> 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 ____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child's Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other _____ Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No		Language Spoken at Home <input type="checkbox"/> English <input type="checkbox"/> Other: _____	Child is on an IEP or IFSP (They receive special ed. services) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child has a diagnosed Medical Condition: <input type="checkbox"/> Yes <input type="checkbox"/> No Child has known allergies: <input type="checkbox"/> Yes <input type="checkbox"/> 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 ____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Lives with Child? <input type="checkbox"/> Yes <input type="checkbox"/> No
Parent's Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other _____ Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No		Relationship to Child: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian o Foster Parent o Court Ordered o Parent Appointed <input type="checkbox"/> Other _____	Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Student <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Stay at home parent <input type="checkbox"/> Retired/Disabled	
Parent's Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Other _____		Parent is a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No Parent is a member of the military? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Preferred Contact Method: <input type="checkbox"/> Phone Call # _____ <input type="checkbox"/> Text # _____ <input type="checkbox"/> Email _____		Parent Education Level: <input type="checkbox"/> High School-Not Graduated <input type="checkbox"/> 2 Year Degree <input type="checkbox"/> High School-Graduated <input type="checkbox"/> 4 Year Degree <input type="checkbox"/> GED <input type="checkbox"/> Master's Degree		
Parent is a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No Parent is a member of the military? <input type="checkbox"/> Yes <input type="checkbox"/> No		Place of Work: _____ Work Phone: _____		

Parent/Guardian 2: First Name	Last Name	Date of Birth ____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Lives with Child? <input type="checkbox"/> Yes <input type="checkbox"/> No
Parent's Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other _____ Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No		Relationship to Child: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian o Foster Parent o Court Ordered o Parent Appointed <input type="checkbox"/> Other _____	Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Student <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Stay at home parent <input type="checkbox"/> Retired/Disabled	
Parent's Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Other _____		Parent is a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No Parent is a member of the military? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Preferred Contact Method: <input type="checkbox"/> Phone Call # _____ <input type="checkbox"/> Text # _____ <input type="checkbox"/> Email _____		Parent Education Level: <input type="checkbox"/> High School-Not Graduated <input type="checkbox"/> 2 Year Degree <input type="checkbox"/> High School-Graduated <input type="checkbox"/> 4 Year Degree <input type="checkbox"/> GED <input type="checkbox"/> Master's Degree		
Parent is a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No Parent is a member of the military? <input type="checkbox"/> Yes <input type="checkbox"/> No		Place of Work: _____ Work Phone: _____		

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
				<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> 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)

- | | |
|---|---|
| <input type="checkbox"/> Salary or Wages* | <input type="checkbox"/> Energy Assistance |
| <input type="checkbox"/> Child Support Received* | <input type="checkbox"/> Food Support |
| <input type="checkbox"/> MFIP or DWP* | <input type="checkbox"/> Housing/HUD |
| <input type="checkbox"/> Self Employment * | <input type="checkbox"/> Subsidized Childcare |
| <input type="checkbox"/> SSI/Disability* | <input type="checkbox"/> Medical Assistance |
| <input type="checkbox"/> Unemployment Comp.* | <input type="checkbox"/> WIC |
| <input type="checkbox"/> Social Security* | |
| <input type="checkbox"/> Veteran's Benefits* | |
| <input type="checkbox"/> Retirement/Pension* | |
| <input type="checkbox"/> Interest/Other* | |
| <input type="checkbox"/> No Income – Explain: _____ | |
-

* 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 ____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> 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 ____/____/____

01/2018

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 ____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> 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

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- 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 ____/____/____