ICCC Head Start Application

Please fill out this application to the best of your ability in **BLUE or BLACK** ink. All information on this application is confidential. You are not required to fill out all information, but incomplete or inaccurate information may prevent us from determining your eligibility. If you have questions or need assistance, please call 1-888-778-4008 ext. 1029.

Applicant (Child) Information

First Name:	Middle Name:	Last Name:	Date of Birth: ___/___/___	Gender: ❑ Male ❑ Female
Race: ❑ American Indian/Alaskan Native ❑ Asian ❑ Black ❑ White ❑ Multiracial ❑ Other: _____	Hispanic/Latino: ❑ Yes ❑ No	Language(s) ❑ English ❑ Spanish ❑ Other: _____	Does your child have a medical condition? ❑ Yes ❑ No Explain: _____	When do you want services to start? ❑ Immediately ❑ Fall

Service Preference:

❑ Home Based (Ages 0-5)
❑ Clubhouse Combination (3 year olds, 5 mornings a week, McIntosh)
❑ Combination Classroom (4 year olds, 2 days a week, Oklee, Fosston, Win-E-Mac (WEM is 2 days & every other Friday)
❑ Center Classroom (4 year olds, 4 days a week, Bagley, Thief River Falls)

Living Address	Mailing Address (If Different):
Line 1: _____ Line 2: _____ City: _____ Zip Code: _____	Line 1: _____ Line 2: _____ City: _____ Zip Code: _____

Directions to your home:	Does your family: ❑ Own your home ❑ Rent your home ❑ Live with family/friends ❑ Live in a shelter	
	County:	School District:

Parent/Guardian 1 Information

First Name:	Last Name:	Lives with Child? ❑ Yes ❑ No	Date of Birth: ___/___/___	Gender: ❑ Male ❑ Female
Relationship to Child: ❑ Biological/Step Parent ❑ Legal Guardian ❍ Foster Parent ❍ Court Ordered ❍ Parent Appointed ❑ No relation	Race: ❑ American Indian/Alaskan Native ❑ Asian ❑ Black ❑ White ❑ Multiracial ❑ Other: _____	Hispanic/Latino: ❑ Yes ❑ No	Language(s): ❑ English ❑ Spanish ❑ Other: _____	

Parent/Guardian 1 Information Continued:

Employment Status:	Place of Work:	Military Status:	Highest Education Level:
❑ Full Time ❑ Part Time ❑ Student/Returning for GED ❑ Seasonal ❑ Self-Employed ❑ Unemployed ❑ Stay at Home Parent ❑ Retired/Disabled	_____ Work Phone: _____	❑ Active Duty ❑ Is deployed or will be deployed soon ❑ Veteran ❑ Not applicable	❑ Grade 9 or less ❑ Grade 10 ❑ Grade 11 ❑ High School Graduated ❑ GED ❑ 2 Year Degree ❑ 4 Year Degree ❑ Master's Degree

Preferred Contact Method:	Alternate Contact Information:
❑ Phone Number: _____ ❑ Can Text ❑ Email: _____	Phone Number: _____

Parent/Guardian 2 Information

First Name:	Last Name:	Lives with Child?	Date of Birth:	Gender:
		❑ Yes ❑ No	___/___/___	❑ Male ❑ Female

Relationship to Child:	Race:	Hispanic/Latino:	Language(s):
❑ Biological/Step Parent ❑ Legal Guardian ❍ Foster Parent ❍Court Ordered ❍Parent Appointed ❑ No relation	❑ American Indian/Alaskan Native ❑ Asian ❑ Black ❑ White ❑ Multiracial ❑ Other: _____	❑ Yes ❑ No	❑ English ❑ Spanish ❑ Other: _____

Employment Status:	Place of Work:	Military Status:	Highest Education Level:
❑ Full Time ❑ Part Time ❑ Student/Returning for GED ❑ Seasonal ❑ Self-Employed ❑ Unemployed ❑ Stay at Home Parent ❑ Retired/Disabled	_____ Work Phone: _____	❑ Active Duty ❑ Is deployed or will be deployed soon ❑ Veteran ❑ Not applicable	❑ Grade 9 or less ❑ Grade 10 ❑ Grade 11 ❑ High School Graduated ❑ GED ❑ 2 Year Degree ❑ 4 Year Degree ❑ Master's Degree

Preferred Contact Method:	Living Address (if different from above):
❑ Phone Number: _____ ❑ Can Text ❑ Email: _____	Line 1: _____ Line 2: _____ City: _____ Zip Code: _____

Emergency Contact Information (Not a Parent/Guardian)

Name: _____	Name: _____
Phone Number: _____	Phone Number: _____
Relationship to Child: _____	Relationship to Child: _____

Other People in the Home Not Already Listed

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
				❑Male ❑Female		❑Yes ❑No

Environmental Factors

In an effort to best serve your child/family, **please check** any of the following conditions or situations that currently affect or have affected the child's household. The information is confidential. You are not required to provide any information, but the information helps us provide the best services to your family.

❑ Child receives Special Education Services or has an IEP/IFSP.
❑ Parent/Guardian has developmental concerns about child.
❑ Parent was a teen parent when the child was born.
❑ Household member with disability or health condition
❑ Domestic violence (past or present)
❑ Parent substance abuse
❑ Documented or suspected child abuse (past or present)
❑ Household member with mental health issues
❑ Death of immediate family member
❑ Parent/Guardian feels lack of social support system
❑ Homeless in last 12 months
❑ Decrease in family income
❑ One family member is out of the home for an extended period of time (deployment, hospitalization, job related, etc.)
❑ Family's school or childcare closed temporarily due to COVID
❑ Family was negatively affected by COVID
❑ Other: _____

Income Information

Because Head Start receives funding from the Department of Health and Human Services, we must verify your family's income. Please mark all forms of income you have received in the last 12 months or in 2020. Please attach income documentation for the last year such as a 1040 or W2 tax form.

- ❑ Salary or Wages
- ❑Child Support
- ❑ MFIP/DWP (cash assistance)
- ❑ Self-Employment
- ❑ SSI/Disability
- ❑ Unemployment Compensation
- ❑ Social Security
- ❑ Veteran's Benefits
- ❑ Retirement/Pension
- ❑ College Grants/Scholarships
- ❑ Interest/Other
- ❑ No Income—Explain: _____
  _____

If you receive Child Support, MFIP, or the child is in foster care, please complete the following release and we will fax for verification. **All other forms of income verification must be provided by you.**

ICCC Head Start has permission to request income information from:

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

❑ Social Services (for foster care or kinship care placement): _____
County

❑ Child Support Services: _____
County

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/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.

Sign and Date Application

Parent/Guardian Signature: _____ Date: ___/___/___

Parent/Guardian Signature: _____ Date: ___/___/___

Return completed applications and income verification to:

ICCC Head Start, PO 189, Oklee, MN, 56742

Or email: headstart@intercountycc.org

OFFICE USE:
Staff Initials: _____
Interview Initials: _____
❑ Phone Int. ❑ In Person Int.

Updated 2021

RELEASE OF INFORMATION

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_____/_____/_____