# The Center

Early Childhood Programs
Lake County School District R-1

315 West 6th Street
Leadville, CO 80461

Phone 719 486-6928
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*Head Start, Colorado Preschool Program, Tuition-Based Preschool and School Age Programs, Services for Children with Special Needs, Early Head Start*

## Early Head Start
Learning Begins at Birth

Early Head Start is a home visiting program designed to support you as your child's first and most important teacher. You are eligible to apply if you are pregnant or have children up to three years old.

**The following items must be included with your application:**

- ☐ Child's Birth Certificate
- ☐ Child's Immunization Record - Must be up-to-date on immunizations
- ☐ Health Insurance Card - Private Insurance, Medicaid, or CHP+
  If no health insurance - Please pick up an application from Mary in Room 9
- ☐ CACFP (Child and Adult Food Care Program) Eligibility form
- ☐ Income eligibility:
  * 1040 Tax Form from 2017 or W-2 forms from 2017 or
  * Check stubs representing one year of income
  * Statement from Employer for one year of income or
  * Documentation of a TANF or SSI award or
  * Documentation of foster care status.

Once you have completed and signed this application, please bring it and the required supporting documents to The Center or call _____

***Please note**: This application is printed on the front and back of the page.*

Completion of this application does not guarantee your child a place in the program.

If you have any questions at all, or if you would like assistance completing this application, please call Lisa at 719-486-6925 or Jenny at at 719-486-6925 for Spanish.

| **Date and Time Received by Office:** | **Person receiving application:** |
|---|---|
| | |

# The Center Early Head Start
# Lake County Schools
# 2018-2019 Application Form

Revised 8/31/18

EARLY HEAD START

*Please read the questions carefully and provide the most accurate information possible.*

**OFFICE USE ONLY**
Enrollment Date _____ Entry Date_____

## Child Information

| Last Name | First Name | Middle Name | Nickname |
|---|---|---|---|
| | | | |

| Date of Birth | Birthplace | ☐ Male ☐ Female | |
|---|---|---|---|
| | | | |

Lives with (check all that apply): ☐ Mom ☐ Dad ☐ Both ☐ Mom's Partner ☐ Dad's Partner ☐ Grandparents ☐ Foster Parents ☐ Other _____

If a parent does not live in the child's home, do we have permission to contact them?
☐ Yes ☐ No

Is there a court order affecting your child? ☐ Yes ☐ No

If yes, you must provide a copy
Details of order-

## Language / Race / Ethnicity Questionnaire

| | |
|---|---|
| Primary Language spoken at home : | ☐ English ☐ Spanish ☐ Both ☐ Other :_____ |
| Primary Language for letters sent home : | ☐ English ☐ Spanish ☐ Both ☐ Other :_____ |
| Ethnicity :<br>Please mark one. | ☐ Hispanic or Latino origin ☐ Non-Hispanic or Latino origin |
| Race :<br>Please mark one or more. | ☐ American Indian or Alaska Native ☐ Pacific Islander or Native Hawaiian<br>☐ Asian ☐ White ☐ Black or African-American ☐ Other :_____ |

## Mother / Guardian Information

| Name | Mailing Address |
|---|---|
| | |

| Date of Birth | Physical Address |
|---|---|
| | |

| Preferred daytime contact | Home Phone | Cell or Message | Email Address |
|---|---|---|---|
| | | | |

| Employer | Employer Address | Work Phone |
|---|---|---|
| | | |

Does Mother live with child? ☐ Yes ☐ No

Does Mother have legal custody? ☐ Yes ☐ No

Mother's Employment Information : ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Unemployed ☐ Seeking Employment ☐ Homemaker ☐ In job training or school ☐ Disabled ☐ Retired ☐ Actively Deployed Military

Mother's Education Information : ☐ Less than High School Diploma ☐ High School Diploma or GED ☐ Some college, vocational, AA/AS degree ☐ Bachelor or Advanced College degree

Mother's Educational Goals : ☐ GED classes ☐ English classes ☐ college classes ☐ parenting classes ☐ Other

Was mother under 18 at time of this child's birth? ☐ Yes ☐ No

Was mother unmarried at the time of this child's birth? ☐ Yes ☐ No

## Parent/Guardian Signatures

| Mother/Guardian Signature | Date | Father/Guardian Signature | Date |
|---|---|---|---|
| | | | |

**Father / Guardian Information**

| Name | | Mailing Address | |
|---|---|---|---|
| Date of Birth | Physical Address | | |
| Preferred daytime contact | Home Phone | Cell or Message | Email Address |
| Employer | Employer Address | Work Phone | |
| Does Father live with child? ☐ Yes ☐ No | | Does Father have legal custody? ☐ Yes ☐ No | |

Father's Employment Information : ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Unemployed ☐ Seeking Employment
☐ Homemaker ☐ In job training or school ☐ Disabled ☐ Retired ☐ Actively Deployed Military

Father's Education Information : ☐ Less than High School Diploma ☐ High School Diploma or GED
☐ Some college, vocational, AA/AS degree ☐ Bachelor or Advanced College degree

Father's Educational Goals : ☐ GED classes ☐ English classes ☐ college classes ☐ parenting classes ☐ Other

Was father under 18 at time of this child's birth? ☐ Yes ☐ No
Was father unmarried at the time of this child's birth? ☐ Yes ☐ No

**Other Adult Caregiver in Home: ☐ Guardian ☐ Step Parent or ☐ Live-in Partner Information** (check one)

**Is this person related to the applicant child by blood or through a marriage or adoption?** ☐ Yes ☐ No

| Name | | Date of Birth | |
|---|---|---|---|
| Preferred daytime contact | Home Phone | Cell or Message | Email Address |
| Employer | Address | Work Phone | |

Caregiver's Employment Information : ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Unemployed ☐ Seeking Employment
☐ Homemaker ☐ In job training or school ☐ Disabled ☐ Retired ☐ Actively Deployed Military

**List all other family members not listed above who live in your household and for whom you are responsible for the care and welfare.**

| Name | Relationship to child | Date of Birth | Is this person related to the child's parent(s) | Is this person supported by the parent(s) income? |
|---|---|---|---|---|
| | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No | ☐ Yes ☐ No |

**Total number of people living in the household (including you) for whom you provide financial support.**

The Center respects and protects your family's privacy. The information you provide in this enrollment packet will be used to determine you eligibility for programs and services and will not be shared without your permission.

I understand this is an application for services that may be paid for with government funds and that intentionally providing misleading, inaccurate, or untruthful information may result in my child being terminated from the program.

*** I understand this is an application only and does not guarantee enrollment in the program ***

**Parent/Guardian Signatures**

| Mother/Guardian Signature | Date | Father/Guardian Signature | Date |
|---|---|---|---|
| | | | |

**Special Considerations** (Check all that apply to your household and add any extra information you would like to provide.)

| | |
|---|---|
| ☐ Developmental concerns | ☐ Speech / language concerns |
| ☐ Substance abuse | ☐ Family member incarcerated |
| ☐ Family violence / abuse | ☐ Family in crisis |
| ☐ Child in out of home placement | ☐ Previously in Head Start |
| ☐ Referral from agency<br>Name of agency:_____ | ☐ Other- (Please describe): |

**Child Residency Questionnaire**

This questionnaire is intended to address the McKinney-Vento Homeless Education Assistance Improvements Act 42 USC 11435. The answers to this residency information help determine the services the child may be eligible to receive.

1. How many times has your family / child moved in the last 3 years? _____

2. Is your current address a temporary living arrangement? ☐ Yes ☐ No

3. Is this temporary living arrangement due to loss of housing or economic hardship? ☐ Yes ☐ No

**If you answered YES to the above questions, please complete the remainder of this section.**
**If you answered NO, you may skip to the next section.**

| | | |
|---|---|---|
| Where is the child presently living?<br><br>(Check one box) | ☐ In a motel or hotel | ☐ In an emergency or transitional shelter |
| | ☐ Awaiting foster care placement | ☐ With more than one family in a house or apartment |
| | ☐ Abandoned in a hospital | ☐ Moving from place to place |
| | ☐ In a place not designed for ordinary sleeping accommodations, such as a car, park, abandoned building, or campsite | |

**Mandated Child Abuse and Neglect Reporting**

This is to inform you that all employees of The Center Early Childhood Programs are required by State Law to report all instances of suspected child abuse/neglect to the Lake County Department of Human Services. This agency will visit The Center to evaluate the circumstances, and if abuse or neglect is determined, and if the child is felt to be in danger of further abuse or neglect, the Department of Human Services will call the legal authorities and request that they take the child into protective custody, and they will notify you of the steps you must take.

**Parent's Initials** _____

**Parent/Guardian Signatures**

*** I understand this is an application only and does not guarantee enrollment in the program ***

| Mother/Guardian Signature | Date | Father/Guardian Signature | Date |
|---|---|---|---|
| | | | |

**Information Release**

I give permission for The Center Early Childhood Programs to exchange information with the following community partners for the purpose of providing the best services for my child and family. This authorization will continue in force until revoked by me in writing, and a copy or fax shall serve in its stead. This includes permission to copy, release, or discuss information with the purpose of facilitating interagency communication in providing services to myself and my family. **Parent's Initials** _____

| | |
|---|---|
| • Lake County School District | • Family Literacy Program |
| • Lake County Department of Human Services | • Disabilities Services Provider and Coordinator |
| • Lake County Public Health Agency | • WIC Nutrition Program |
| • My child's medical and dental care providers | • SolVista Health |

**Photo and Video Release**

| | |
|---|---|
| ☐ Yes ☐ No | I authorize The Center Early Childhood Programs to photograph or permit photographs to be taken and for the filming of video of my child named above. The photos or videos may be posted in The Center, published in the newsletter, on The Center's website or social media pages, news media, or used in promotional materials for these programs. |

**Medical and Dental Information**

**Do you have a primary health care provider who provides your prenatal care or your child's regular health care? □ Yes □ No**

**Provider's Name_____Address_____Phone_____**

**Do you have medical coverage or insurance? □ Yes (please bring the card to make a copy) □ No**
**If "Yes" what type □ Medicaid ID# _____**
**□ CHP+ ID# _____**
**□ Private insurance Company Name & Policy #_____**
**Does your insurance include dental coverage? □ Yes □ No**
**If "No", please request an application for Medicaid and CHP+. Assistance is available with form completion**

Has your child been seen by a dentist before? ☐ Yes ☐ No
When was your child's last dental appointment? _____
Please list the preferred dentist for your child's dental care:

Dentist Name_____ Address_____ Phone _____

**Medical History and Special Concerns**

Is your child seeing a medical specialist for any reason? ☐ Yes ☐ No
If yes, please explain :
_____
Specialist's Name_____ Address_____ Phone _____

Has your child had a serious injury, accident, been hospitalized or had surgery? ☐ Yes ☐ No
If yes, please explain :
_____

Is your child being treated for a medical, disabling or mental health condition? ☐ Yes ☐ No
If yes, please explain : _____

Is your child currently taking any medication or does he/she require any medical procedures? ☐ Yes ☐ No
If yes, what type? _____

Will this medicine or medical procedure be given at school? ☐ Yes ☐ No
(Note : Doctor's written authorization is needed before any medication/or procedure can be given at school.)

Are there health problems or conditions that will limit activities or affect your child at school? ☐ Yes ☐ No
If Yes, please explain :

**Immunizations**

Is your child up to date on their immunizations? ☐ Yes ☐ No
(Note : Either a copy of your child's immunization records or a signed Statement of Exemption must be on file)

**Disability**

Does your child have a diagnosed disability? ☐ Yes ☐ No
If yes, what is the disability?
_____

Is your child on an Individual Family Services Plan (IFSP)? ☐ Yes ☐ No
If yes, what is the IFSP for? _____

Do you have other concerns about other children in your family who may have delays and or disabilities? ☐ Yes ☐ No
Would you like The Center to refer you to the Child Find early intervention program to help with your concerns? ☐ Yes ☐ No

**Parent's Initials**_____

**Child's Medical Background and Health Concerns**

**Does your child now suffer from or have they suffered in the past from: (Please check all that apply.)**

| | | |
|---|---|---|
| ☐ Asthma<br>Will your child require an inhaler or nebulizer at school? ☐ Yes ☐ No<br>What are the asthma triggers? | ☐ Visual Problems<br>(Difficulty seeing, headaches, wears glasses) | ☐ Hearing Problems<br>(Hearing aids, diffuculty hearing, frequent earaches, tubes in ears) |
| ☐ Skin Problems<br>(Eczema, Hives, etc.) | ☐ Bone, Joint or Muscle Injury Or Bone Disease | ☐ Speech Problems<br>(Hard to understand, Talked late) |
| ☐ Pneumonia/RSV | ☐ Cancer | ☐ Kidney Disease |
| ☐ Bleeding Disorder | ☐ Anemia or Sickle Cell Anemia | ☐ Gastro Esophageal Reflux (GER) |
| ☐ Diabetes | ☐ Seizures/Convulsions | ☐ Meningitis |
| ☐ Hepatitis | ☐ Heart Disease | ☐ Leukemia |
| ☐ Rheumatic Fever | ☐ Frequent fevers | ☐ Sinus problems |
| ☐ Orthopedic Problems | ☐ Lead Poisoning | ☐ Tuberculosis |
| ☐ Frequent stomach aches, indigestion, or vomiting | ☐ Constipation, diarrhea, frequent or painful urination | ☐ Fainting Spells |
| ☐ Whooping Cough | ☐ Trouble chewing or swallowing | ☐ Second hand smoke |
| ☐ Wears diapers or pull ups | ☐ Other: | |

| | |
|---|---|
| Has this child ever passed out during extreme physical exertion? | ☐ Yes ☐ No |
| Has anyone in the family suffered a sudden, unexplained death before the age of 50? | ☐ Yes ☐ No |

Please explain any concerns listed above:

Parent/Guardian Signatures

* I understand this is an application only and does not guarantee enrollment in the program *

| | | | |
|---|---|---|---|
| Mother/Guardian Signature | Date | Father/Guardian Signature | Date |