



USD Head Start Enrollment Application

414 E Clark Street
Julian Hall Room 326
Vermillion SD 57069
www.usd.edu/headstart

605-677-5235
1-800-813-8132
FAX 605-677-6597

For Office Use Only: Application for Early Head Start Head Start
 Acceptance Date: _____ Enrollment Date: _____
 Entry Date: _____/_____/_____ Age: _____
 Home Visitor/Teacher: _____
 Eligibility Status: Eligible Over- Income Application Processed by _____

Please complete application thoroughly. Information provided helps to determine placement.

Applicant Information: (Child or Expectant Woman)				
First Name	Middle Name	Last Name	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address where applicant/child resides:			Mailing Address:	
Street:			Street/PO Box:	
Town/City:		State:	Zip Code:	Town/City:
		State:	Zip Code:	
County:			School District:	
Applicant lives with: (Check all that apply) <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step Father <input type="checkbox"/> Step Mother <input type="checkbox"/> Foster Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Grandparent(s) <input type="checkbox"/> Other, specify: _____	What is the applicant's Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/ Alaskan Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Bi-racial/Multi-Racial <input type="checkbox"/> Other: _____	What is the applicant's Ethnicity: <input type="checkbox"/> White-non-Hispanic <input type="checkbox"/> Hispanic or Latin Origin Language(s) spoken in the child's home? Primary: _____ Secondary: _____ How well does the applicant speak English? _____	Currently Enrolled in Head Start or Early Head Start: <input type="checkbox"/> Center- <input type="checkbox"/> Early Head Start <input type="checkbox"/> Home-Based Based Date enrolled: _____ Program Name: _____ Address: _____	
Household Composition: List the primary caregivers.				
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Other				
Parent/Guardian: (If applicant is under the age of 18 parent/guardian information is required.)				
First Name		Middle Name	Last Name	
Date of Birth:		Relationship to child:		
Telephone Number Information: Home: _____ Work: _____		Cell phone: _____ Message: _____		
E-mail: _____		Address if different than above: _____		
Are you employed: <input type="checkbox"/> Part time <input type="checkbox"/> Full time <input type="checkbox"/> Seasonally <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Self-employed <input type="checkbox"/> Disabled Employer Name: _____ Starting Date: _____ Highest level of education completed: <input type="checkbox"/> 9 th grade or less <input type="checkbox"/> 10 th grade <input type="checkbox"/> 11 th grade <input type="checkbox"/> High School Graduate <input type="checkbox"/> GED <input type="checkbox"/> Training Certificate <input type="checkbox"/> Vocational <input type="checkbox"/> Associates <input type="checkbox"/> Bachelor <input type="checkbox"/> Master's <input type="checkbox"/> Advanced <input type="checkbox"/> Other _____ Are you attending school/job training? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where? _____ Area of Study: _____				
Parent/Guardian: (If applicant is under the age of 18 parent/guardian information is required.)				
First Name		Middle Name	Last Name	
Date of Birth:		Relationship to child:		
Telephone Number Information: Home: _____ Work: _____		Cell phone: _____ Message: _____		
E-mail: _____		Address if different than above: _____		
Are you employed: <input type="checkbox"/> Part time <input type="checkbox"/> Full time <input type="checkbox"/> Seasonally <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Self-employed <input type="checkbox"/> Disabled Employer Name: _____ Starting Date: _____ Highest level of education completed: <input type="checkbox"/> 9 th grade or less <input type="checkbox"/> 10 th grade <input type="checkbox"/> 11 th grade <input type="checkbox"/> High School Graduate <input type="checkbox"/> GED <input type="checkbox"/> Training Certificate <input type="checkbox"/> Vocational <input type="checkbox"/> Associates <input type="checkbox"/> Bachelor <input type="checkbox"/> Master's <input type="checkbox"/> Advanced <input type="checkbox"/> Other _____ Are you attending school/job training? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where? _____ Area of Study: _____				
Other Household Member Information: Please list all other persons living within the home not listed above.				
First Name	Last Name	Date of Birth	Relationship to child	If an adult, does this person provide support for the child? (i.e. money, shelter, clothing, etc.)

Child Care Provider Information:		
Will this child be cared for by someone other than you, in addition to participating in this program? If yes, please fill out the following information.		
<input type="checkbox"/> Older sibling, 13 or older <input type="checkbox"/> Relative <input type="checkbox"/> Not yet arranged <input type="checkbox"/> Child Care Center <input type="checkbox"/> Other, Specify _____	<input type="checkbox"/> Adult non-relative in child's own home <input type="checkbox"/> Adult non-relative in non-relative's home <input type="checkbox"/> Would like information on child care directory <input type="checkbox"/> Would like information about child care assistance	_____ Number of hours per day child care needed If you need full time childcare, are you interested in Full Day/Full Year Head Start Services? <input type="checkbox"/> Yes <input type="checkbox"/> No
Child Care Provider Name:	Address:	Telephone:
Family Resource Information:		
Does your family receive any of the following types of services or financial assistance? (please indicate all that apply)		
<input type="checkbox"/> CHIP/Medicaid <input type="checkbox"/> Food Stamps / SNAP <input type="checkbox"/> Public Assistance-TANF <input type="checkbox"/> WIC <input type="checkbox"/> Child Care Assistance <input type="checkbox"/> Foster Care/Adoption subsidy	<input type="checkbox"/> Grants/Scholarships <input type="checkbox"/> Financial Aid/Student Loans <input type="checkbox"/> Unemployment Insurance <input type="checkbox"/> Public Housing Assistance <input type="checkbox"/> Energy Assistance <input type="checkbox"/> Child support/alimony	<input type="checkbox"/> Supplemental Security Income (SSI) <input type="checkbox"/> Social Security Disability Income (SSDI) <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Mental Health Services <input type="checkbox"/> Receiving no services <input type="checkbox"/> Other _____ Is child support up to date? _____
What is your current living arrangement/situation: <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Motel <input type="checkbox"/> Receive Subsidized Housing <input type="checkbox"/> Shelter/Mission <input type="checkbox"/> Homeless- live with others because I have no alternative <input type="checkbox"/> Live with Relatives/Friends by choice How long have you lived at this address: <input type="checkbox"/> Other, Specify _____		
Does your family currently have reliable means of transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Number of vehicles If yes, please specify: <input type="checkbox"/> Private vehicle <input type="checkbox"/> Friend's or relative's vehicle <input type="checkbox"/> Public transportation <input type="checkbox"/> Other: _____		
Are there any other crisis, concerns or family situations that we should be aware of to help meet your child's needs (such as recent divorce, parental health, counseling, recent moves, parent absent because they are in the military, incarcerated, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:		
Custodial Information:		
<input type="checkbox"/> Does not apply in my situation <input type="checkbox"/> Sole Custody <input type="checkbox"/> Joint Custody—both biological parents	<input type="checkbox"/> Joint Custody—other; explain _____ <input type="checkbox"/> Physical Custody; explain who has legal custody _____	
Is there a protection or restraining order regarding the child? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please explain and provide a copy with your application)	Are there special visitation orders we should be aware of? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please explain and provide a copy with your application) <input type="checkbox"/> Foster Care/Custody of State of South Dakota Caseworker: _____ Phone _____ Agency: _____	
Additional Information:		
Is anyone in your household currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Due Date: _____ If yes, would you like information or an application about the USD Head Start services for expectant families? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please mark in the following box(es): <input type="checkbox"/> Application <input type="checkbox"/> Information <input type="checkbox"/> Both		
Referred By:	<input type="checkbox"/> Friend or Relative <input type="checkbox"/> Health Care Provider/Dentist <input type="checkbox"/> WIC Office/County Health <input type="checkbox"/> School, Early Childhood or Birth –Three Program	<input type="checkbox"/> Dept of Labor(Career Center) <input type="checkbox"/> Other Head Start Program <input type="checkbox"/> Newspaper <input type="checkbox"/> Church <input type="checkbox"/> Poster/Sign
<input type="checkbox"/> Head Start Staff <input type="checkbox"/> Program Brochure <input type="checkbox"/> Head Start Mailing <input type="checkbox"/> Other Specify: _____		
For Office Use Only This applicant qualifies based on <input type="checkbox"/> Eligibility <input type="checkbox"/> Homelessness <input type="checkbox"/> TANF <input type="checkbox"/> SSI <input type="checkbox"/> Foster Care <input type="checkbox"/> Zero Income		
Family Size _____ Family Income _____ Total Income _____	Verification Source of Income _____ _____ _____ Re-verification Source of Income _____ _____ _____	Time Period: <input type="checkbox"/> Last 12 months <input type="checkbox"/> Last Calendar Year Income Verification Source: <input type="checkbox"/> 1040 Tax Statement <input type="checkbox"/> W-2 Statement <input type="checkbox"/> Pay Stubs <input type="checkbox"/> Income Declaration <input type="checkbox"/> Unemployment <input type="checkbox"/> Public Assistance <input type="checkbox"/> Financial Award Letters <input type="checkbox"/> Other _____
Witness:	Position:	Date:

Child's name: _____	Birthdate: _____	HV/Teacher: _____
Health, Nutrition & Developmental Information		
Applicant's Physician/Health Care Provider Name: _____	Address: _____	Date of Last Exam: _____
Health Care Coverage Information: <input type="checkbox"/> CHIP/Medicaid ID# _____ <input type="checkbox"/> Indian Health Service <input type="checkbox"/> Tri-Care ID# _____ <input type="checkbox"/> Private Health Insurance: _____ Policy#: _____ <input type="checkbox"/> No Medical Health Coverage My child is on WIC <input type="checkbox"/> Yes <input type="checkbox"/> No County: _____		
Applicant's Dentist/Dental Care Provider Name: _____	Address: _____	Date of Last Exam: _____
Dental Care Coverage Information: <input type="checkbox"/> No Coverage <input type="checkbox"/> CHIP/Medicaid <input type="checkbox"/> Dental Insurance _____ Policy #: _____		
Does the applicant have any health or nutrition related concerns or conditions that the program may need to address? (i.e. asthma, diabetes, failure to thrive, high-risk pregnancy, disabling conditions, pre-mature birth, substance abuse, mental health issues, or other) <input type="checkbox"/> Yes <input type="checkbox"/> No Are they diagnosed by a health care professional? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____		
Does the applicant have any allergies? (foods, medications, seasonal, insect bites) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list and explain if there is a protocol for emergency intervention: _____		
Does the applicant have any special dietary needs? <input type="checkbox"/> Yes <input type="checkbox"/> No Are they diagnosed by a health care professional? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____		
Do you have any concerns about your child's development? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: _____		
Has your child been diagnosed with a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes please list: _____		
Is the applicant receiving any special services or currently on an IEP (Individual Education Plan) or IFSP (Individual Family Service Plan)? (i.e. medical, speech therapy, physical therapy, occupational therapy, early childhood special education, counseling, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe and provide name and address of service provider: _____		
Provider: _____	Phone: _____	Address: _____
What is the source of your family's drinking water? <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Rural water <input type="checkbox"/> Bottled water (Does it contain fluoride?) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Release of Information (Please write your INITIALS in the yes or no box)		YES <small>Please initial</small>
I give consent for the applicant's education and health care providers (physicians, clinics, hospitals, dentists, specialists, community health nurses, WIC program, education cooperatives, school districts, preschool and daycare providers) to send all information pertaining to the immunization, health, dental, and educational records of the applicant to the USD Head Start Program – 414 E Clark St, Room 326 Julian Hall, Vermillion SD 57069 (I understand that USD Head Start may also share information with the above providers)		NO <small>Please initial</small>
Lead Screening Assessment Please check Yes, No, or Unsure for each of the following questions:		
1. Does your child live in or regularly visit a house or child care facility that was built before 1950?	_____ Yes _____ No _____ Unsure	
2. Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been remodeled (within the last six months)?	_____ Yes _____ No _____ Unsure	
3. Does your child have a sibling or playmate that has or did have lead poisoning or is being treated for high lead levels?	_____ Yes _____ No _____ Unsure	
4. Does your child come in contact with any adult whose work or hobby involves any of the following: home construction/repair, plumbing/pipe fittings, automotive repair/radiators, battery manufacturing/repair, metal casting/plating/smelting/soldering/welding, furniture refinishing, pottery/stained glass, or industrial machinery or equipment?	_____ Yes _____ No _____ Unsure	
5. Has your child ever received blood lead testing? If Yes, what were the results? _____	_____ Yes _____ No _____ Unsure	

The statements and information on this application are true and accurate to the best of my knowledge.			
** To process your application we need a form of income verification – this may include pay stubs, W-2 form, last year's income tax (front page), student financial aid/loan information, public assistance letter, etc.			
Parent Signature: _____	Date: _____	Parent Signature: _____	Date: _____
(If applicant is under the age of 18 - parent/guardian signature is required besides the applicant.)			