USD Head Start Enrollment Application

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www.usd.edu/headstart

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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/Classroom____________________ Application Processed by ________

Eligibility Status: ☐ Categorically Eligible ☐ Income eligible ☐ 100-130% ☐ Over- Income

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

Child Information:

First Name | Middle Name | Last Name | Date of Birth: | Gender: ☐ Male ☐ Female

Address where child resides:
Street:
Town/City: | State: | Zip Code:
County:

Mailing Address:
Street/PO Box:
Town/City: | State: | Zip Code:
School District:

Child lives with:
(Check all that apply)
- ❑ Mother
- ❑ Father
- ❑ Step Father
- ❑ Step Mother
- ❑ Foster Parent
- ❑ Legal Guardian
- ❑ Grandparent(s)
- ❑ Other, specify: ___________

Parent's Marital Status:
- ❑ Single
- ❑ Married
- ❑ Divorced
- ❑ Separated
- ❑ Widowed
- ❑ Other ________________

Parent Health Insurance:
Do you have health care insurance?
Parent/Guardian 1: ☐ yes ☐ no
Parent/Guardian 2: ☐ yes ☐ no

Language(s) spoken in the child's home?
Child's Primary: ____________________
Secondary: __________________
How well does the child speak English? __________________
Parent 1 Primary: __________________
Parent 2 Primary: __________________
Preferred Language: ________________

Is this child currently enrolled in USD Head Start:
☐ yes ☐ no
☐ Early Head Start
☐ Head Start

Is another member of your family currently enrolled in USD Head Start?
☐ yes ☐ no
☐ Early Head Start
☐ Head Start

Household Composition: List the primary caregivers.

Parent/Guardian 1:

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:
☐ Part time ☐ Full time ☐ Seasonally ☐ Retired ☐ Disabled
☐ Unemployed ☐ Self-employed Start Date: ___________
Employer Name:______________________________________

Highest level of education completed:
☐ 9th grade or less ☐ 10th grade ☐ 11th grade
☐ High School Graduate ☐ GED ☐ Training Certificate
☐ Associates ☐ Bachelor ☐ Master's
☐ Advanced/Doctorate ☐ Other____________________

Are you attending school/job training? ☐ Yes ☐ No
If yes, where? ____________________________________
Are you in the United States military? ☐ Yes ☐ Previously ☐ No

Parent/Guardian 2:

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:
☐ Part time ☐ Full time ☐ Seasonally ☐ Retired ☐ Disabled
☐ Unemployed ☐ Self-employed Start Date: ___________
Employer Name:______________________________________

Highest level of education completed:
☐ 9th grade or less ☐ 10th grade ☐ 11th grade
☐ High School Graduate ☐ GED ☐ Training Certificate
☐ Associates ☐ Bachelor ☐ Master's
☐ Advanced/Doctorate ☐ Other____________________

Are you attending school/job training? ☐ Yes ☐ No
If yes, where? ____________________________________
Are you in the United States military? ☐ Yes ☐ Previously ☐ No

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's name:

Family Resource Information:

Does your family receive any of the following types of services or financial assistance? (please indicate all that apply)

- ❑ TANF **
- ❑ Supplemental Security Income(SSI)**
- ❑ Child support payments/alimony **
  Received it 6 or less of the last 12 months? ________
- ❑ Financial Aid Award Letter **
  (Grants and/or Scholarships)
- ❑ Unemployment Insurance **
- ❑ Public Housing Assistance
- ❑ Energy Assistance
- ❑ Adoption subsidy**
- ❑ SNAP/Food Stamps
- ❑ WIC County__________
- ❑ Social Security Disability Income (SSDI) **
- ❑ Mental Health Services
- ❑ Child Care Assistance
- ❑ Receiving no services
- ❑ Other__________________

****Please provide documentation**

What is your current living arrangement/situation: ☐ Own ☐ Rent ☐ Motel ☐ Shelter/Mission ☐ Receive Subsidized Housing
☐ Live with others due to loss of housing, economic hardship or similar reason
☐ Live with Relatives/Friends by choice
☐ Other, Specify ____ How long have you lived at this address: _____________

Does your family currently have reliable means of transportation? ☐ Yes ☐ No _____Number of vehicles
If yes, please specify: ☐ Private vehicle ☐ Friend's or relative's vehicle ☐ Public transportation ☐ Other: _____________

Are there any family situations, concerns or other crisis that we should be aware of to help meet the child's needs (such as recent divorce, parental health, counseling, recent moves, parent absent because they are in the military, incarcerated, etc.)?
☐ Yes ☐ No If yes, please explain:

Is there any family or household member who has a serious health or mental health concern (i.e. substance abuse, depression, etc.) that affects/stresses the child? ☐ Yes ☐ No If yes, please explain:

Custodial Information:

- ❑ Does not apply in my situation
- ❑ Sole Custody
- ❑ Joint Custody—both biological parents
- ❑ Joint Custody—other; explain - ________________________________
- ❑ Physical Custody; explain who has custody ________________________________
- ❑ Foster Care/Custody of State of South Dakota
  Caseworker:________________________________
  Agency:________________________________
  Phone: ________________________________

Is there a protection or restraining order regarding the child?
- ❑ No
- ❑ Yes (Please explain and provide a copy upon acceptance)

Are there special visitation orders?
- ❑ No
- ❑ Yes (Please explain and provide a copy upon acceptance)

Child Care Provider Information:

Will this child be cared for by someone other than you, in addition to participating in this program? ☐ **Yes** ☐ **No**
If yes, please fill out the following information.

Number of hours per day child care is needed_____
- ❑ Relative
- ❑ Not yet arranged
- ❑ Child Care Center
- ❑ In home child care
- ❑ Other Please specify:

Child Care Provider
Name: ____
Telephone: ____

Additional Information:

Is anyone in your household currently pregnant? ☐ Yes ☐ No Due Date: __________________________

If you are pregnant, would you like ☐ an application ☐ information for the USD Head Start services for expectant families?

☐ Not interested at this time.

For Office Use Only **Verification**

Family Size_____ **Family Income ______________**

Witness: 1. ________________________________ **Position:** ______________________________ **Date:** ______________

2. ________________________________ ______________________________ ______________

Re-verification

Family Size_____ **Family Income ______________**

Witness: 1. ________________________________ **Position:** ______________________________ **Date:** ______________

2. ________________________________ ______________________________ ______________

Child's name:

Health, Nutrition & Developmental Information

Child's Physician/Health Care Provider Name:	**Address:**	**Date of Last Exam:**

Health Care Coverage Information:
☐ CHIP/Medicaid ☐ Indian Health Service ☐ Private Health Insurance ☐ Tri-Care ☐ No Health Care Coverage

Child's Dentist/Dental Care Provider Name:	**Address:**	**Date of Last Exam:**

Dental Care Coverage Information:
☐ No Coverage ☐ CHIP/Medicaid ☐ Dental Insurance____

Does the child have any health related concerns or conditions?
For example: asthma/reactive airway disease, diabetes, failure to thrive, high lead levels, anemia, disabling conditions, pre-mature birth, mental health issues, seizures/seizure disorder, or other chronic health conditions. ☐ Yes ☐ No
Are they diagnosed by a health care professional? ☐ Yes ☐ No
If yes, please explain: ____

____

Does the child have any allergies?
For example: foods, medications, environmental, seasonal, insect bites. ☐ Yes ☐ No
Are they diagnosed by a health care professional? ☐ Yes ☐ No Is there an emergency protocol in place? ☐ Yes ☐ No
If yes to any of the allergy questions, please explain: ____

____

Does the child have any current special dietary needs or nutrition concerns? ☐ Yes ☐ No If yes, please explain:

____

____

Do you have any concerns about your child's development? ☐ Yes ☐ No If yes, please explain:

____

____

Has the child been diagnosed with a disability? ☐ Yes ☐ No If yes, please explain:

____

____

Is the child receiving any special services or currently on an IEP (Individual Education Program/Plan) or IFSP (Individual Family Service Plan)?
(i.e. medical, speech therapy, physical therapy, occupational therapy, early childhood special education, counseling, etc.)
☐ Yes ☐ No If yes, please provide name and address of service provider

Provider:___________________________Phone:__________________Address:_____________________________________

Release of Information (please write your ***initials*** in the yes or no box)	**Yes**	**No**
I give consent for the program to obtain my child's immunization records from the South Dakota Immunization Information System upon acceptance.		
I give consent for my child's first name, last name, gender, date of birth, race/ethnicity, start and end date of Head Start services to be entered into the State of South Dakota Department of Education's student information system upon enrollment.		
I give consent for the child's name and date of birth to be released to the school districts, education cooperatives, preschool and daycare providers that are in a partnership with the USD Head Start program. ***Authorized consent to the 3 questions above are valid as long as this application remains active.***		

Referred By:

❑ Health Care Provider/Dentist	❑ Dept. of Labor(Career Center)	❑ Head Start Staff
❑ WIC Office/County Health	❑ Other Head Start Program	❑ Program Brochure
❑ School, Early Childhood or Birth –Three Program	❑ Newspaper	❑ Head Start Mailing
❑ Friend or Relative	❑ Church	❑ Other
❑ Department of Social Services	❑ Poster/Sign	Specify:_________________________

The statements and information on this application are true and accurate to the best of my knowledge.

** ***To process your application we need proof of <u>age</u> and a <u>form of income verification</u>.***
To verify income please include last year's income tax return, W-2 form, Student Financial Aid Award Letter, TANF Documentation, SSI Documentation, Child Support Documentation, or pay stubs. Please include a copy of the child's immunization record and birth certificate if available.

Parent Signature: ___________________________________ **Date:** __________

Parent Signature: ___________________________________ **Date:** __________