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/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 Applicant Information:

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

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

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

Applicant 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 ________________

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 applicant speak English? ______________________
Parent 1 Primary: ______________________
Parent 2 Primary: ______________________
Preferred Language: ______________________

Is this applicant 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 applicant:

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 applicant:

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 applicant	If an adult, does this person provide support for the applicant? (i.e. money, shelter, clothing, etc.)

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 applicant'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 applicant? ☐ Yes ☐ No

Custodial Information:

- ❑ Does not apply in my situation
- ❑ Sole Custody
- ❑ Joint Custody—both biological parents
- ❑ Joint Custody—other; explain
  ____
- ❑ Physical Custody; explain who has legal custody
  ____

Is there a protection or restraining order regarding the child?
- ❑ Yes
- ❑ No

(Please explain and provide a copy with your application)

Are there special visitation orders we should be aware of?
- ❑ No
- ❑ Yes (Please explain and provide a copy with your application)
  ____
- ❑ Foster Care/Custody of State of South Dakota

Caseworker:______________________________ Phone_____________
Agency:_________________________________

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

Other, Specify _________

If you need full time childcare in Vermillion, are you interested in Full Day/Full Year Head Start Services? ☐ Yes ☐ No
- ❑ I would like information on child care directory.
- ❑ I would like information about child care assistance.

Child Care Provider Name and address:	**Telephone:**

Additional Information:

Is anyone in your household currently pregnant? ☐ Yes ☐ No Due Date: ___________________________
If yes, would you like information or an application about the USD Head Start services for expectant families? ☐ Yes ☐ No

If yes, please mark in the following box(es): ☐ Application ☐ Information ☐ Both

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

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. ______________________________ ______________________________ ________________

Applicant's name: **Birthdate:**

Health, Nutrition & Developmental Information

Applicant'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

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

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

Does the applicant have any health related concerns or conditions? (i.e. asthma/reactive airway disease, diabetes, failure to thrive, 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/list: ____
____

Does the applicant have any allergies? (foods, medications, 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 applicant 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 describe:
____
____

Has the applicant been diagnosed with a disability? ☐ Yes ☐ 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.)
☐ Yes ☐ 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?
☐ City water ☐ Well water ☐ Rural water ☐ Bottled water (Does it contain fluoride?) ☐ Yes ☐ No

Release of Information (Please write your <u>INITIALS</u> in the yes or no box)	***YES*** Please initial	***NO*** Please initial
I give consent for the applicant's name to be released to the school districts, education cooperatives, preschool and daycare providers that are in a partnership with the USD Head Start program.		

Lead Screening Assessment Please check Yes, No, or Unsure for each of the following questions:

1. Does the applicant live in or regularly visit a house or child care facility that was built before 1950? _____Yes _____No _____Unsure
2. Does the applicant 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 the applicant 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 the applicant 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 the applicant ever received blood lead testing? _____Yes _____No _____Unsure
   If Yes, what were the results? ________________Where was testing done? ____________________________

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 applicant's immunization record and birth certificate if available.***

Parent Signature: ____________________________________ Date: ___________

Parent Signature: ____________________________________ Date: ___________