In order for your child's application to be considered for Head Start, we must have the following items attached to the application…

- ✓ Income Verification (income tax, W-2, child support, income for ***all*** employment in last 12 months, SNAP, SSI)
- ✓ Proof of Birth (birth certificate, hospital record, baptismal record, proof of guardianship-if applicable)
- ✓ Proof of Residency (utility bill – electric, gas) –needs to be in child file
- ✓ Foster forms (if applicable)
- ✓ Medicaid, CHIPS or Private Insurance Verification
- ✓ Immunization Records

Front & Back
Intake Form 1
Family Information

Child's Name: _____ Date of Application: ____/_____/____

1. **Type of housing** (check only one):

☐House ☐Mobile home/trailer ☐Hotel/motel room ☐Rent to own

☐Apartment ☐Community shelter ☐Homeless/no housing ☐Other: _____

2. **Housing payment arrangement** (check only one):

☐Exchange services for housing ☐Rent housing ☐Received subsidized housing

☐Make no payment for housing ☐Own housing ☐Other: Specify _____

3. **Length of time at current address**: 4. Number of moves in the past 12 months? _____

☐ less than 6 months ☐ 6-12 months ☐ 1-2 years ☐ more than 2 years

5. **Homeless** in past 12 months (including current homelessness): ☐yes ☐no

5a. Length of time homeless: ☐ Less than 1 month ☐ 1-3 months ☐ 3-6 months ☐More than 6 months

5b. Family acquired housing during enrollment year: ☐ yes ☐ no

Student Residency Questionnaire

Where is the student presently living? (Check One)
___In his/her own house or apartment (Parent or Guardian listed on the lease or mortgage)
___In home of relatives or friends (Parent or Guardian is not listed on the lease or mortgage)
___In a motel, hotel, RV trailer or campground due to lack of other accommodations
___Unsheltered (or moving from place to place)
___In a shelter or transitional living facility

Is the current living situation temporary due to loss of housing or economic hardship? YES or NO
Is the child living with a non-custodial relative due to the incarceration of his/her custodial parent? YES or NO

6. Family currently has *primary* means of transportation: ☐ yes ☐ no

Indicate *primary* means of transportation by checking the box(es) that apply.

☐ Private Vehicle (car, truck, van) ☐ Friend/Relative's vehicle ☐ School Bus

☐ Public Transportation ☐ City Bus ☐ Other ☐ Taxi ☐ Parent Transport

7. Family has *alternate* means of transportation: ☐ yes ☐ no

Indicate *alternate* means of transportation by checking the box(es) that apply.

☐ Private Vehicle (car, truck, van) ☐ Friend/Relative's vehicle ☐ School Bus

☐ Public Transportation ☐ City Bus ☐ Other ☐ Taxi ☐ Parent Transport

Region XIV Head Start program does not own or operate school buses, nor provide transportation. If you would like to request assistance in locating community resources for transportation, please indicate below.

_____ Yes, I would like assistance.

_____ No, I do not need assistance.

8. TYPES OF SERVICES OR FINANCIAL ASSISTANCE CURRENTLY RECEIVING

☐No services received	☐Public Assistance/Welfare (e.g.TANF)	☐SNAP/Food Stamps
☐Child Support/alimony	☐Public Housing Assistance	☐Foster care/adoption
☐Energy program assistance	☐Supplemental Security Income (SSI)	☐WIC
☐EPSDT	☐Unemployment Insurance	
☐Medical financial assistance (e.g. Medicaid/Medicare, CHIP)		
☐Parent Incarcerated	☐Family in need of assistance	☐Previously Enrolled
☐Migrant/Language	☐Teen Parent	☐Homeless
☐Disability	☐Referral from another agency – documented (not an IEP)	

☐Other: Specify _____

Intake Form 2
Certification/Signature Page

PARENT

I certify that information provided is correct to the best of my knowledge and is subject to verification. I am also aware that I may be subject to termination from the program if the information verified disqualifies me from eligibility.

I am aware that I must follow all Head Start Performance Standards including but not limited to Developmental Assessments, Medical exams (Physicals), and Dental exams.

Applicant Signature/Firma del Aplicante: _____ **Print Name of Applicant/Nombre (Use letra imprenta)** _____

Date/Fecha: _____

Parents Do Not Write Below This Line

STAFF

Eligibility Determination Statement I hereby do certify that the family is eligible to participate in the Early Head Start/Head Start Program. Furthermore, I attest that the application/enrollment packet is complete and I have examined the documents (checked) below and certify that the family is eligible in accordance with Head Start regulations and Eligibility-Recruitment-Selection-Enrollment-Attendance policies.

Documents Reviewed (check all that apply):

☐INDIVIDUAL TAX FORM ☐W-2 ☐ CHILD SUPPORT PAYMENTS

☐PAY STUBS/PAY ENVELOPES ☐UNEMPLOYMENT ☐ SOCIAL SECURITY PAYMENTS

☐WRITTEN EMPLOYER STATEMENTS ☐CURRENT PUBLIC ASSISTANCE RECEIPTS (TANF or SNAP)

☐WORK HISTORY- VERIFICATION OF EMPLOYMENT ☐ SUPPLEMENTAL SECURITY INCOME

☐WRITTEN VERIFICATION OF VERBAL DECLARATION OF INCOME ☐ FOSTER CARE

☐OTHER: _____ ☐ HOMELESS

AGENCY SIGNATURES

Interviewed/Assisted By: _____ **Date:** _____/_____/_____

□ In Person □ Telephone □ Virtual

CHILD ACCEPTANCE DATE: _____/_____/_____ (by Region 14 Head Start)

CHILD ENROLLMENT/ ENTRY/ DATE (first day of service) : _____/_____/_____

Region 14 ESC Head Start Staff Only

Staff Eligibility Certification Signature: _____

Certification Date: _____

Intake Form 3
Child Health History

Child's Name_____ **Male**_____ **Female**_____ **DOB**_____ **Age**_____

School_____ **Head Start**_____ **Early Head Start**_____ **Date**_____

***** Does your child have Medical Insurance? Yes_____ No_____ Name of Insurance Company:_____
***** Does your child have Dental Insurance? Yes_____ No_____ Name of Insurance Company:_____
Reason for no medical / dental insurance? Pending_____ (need proof) Re-Applying_____ (need proof) Denied_____ (need proof) Other____
Child's medical doctor? Name_____ Phone_____ Date of Last Physical: _____
How long has your child been seen at this location? _____ Lead level drawn? Yes_____ No_____ Where? _____
Child's dentist? Name_____ Phone_____ Date of Last Dental Visit: _____
How often does your child visit their dentist? Every 6 months_____ Not Regularly_____ Child has never been to a dentist_____
***** Does family receive WIC? Yes____ No____ Do you want information on WIC? Yes____ No____ ***** Does the family receive SNAP? Yes____ No_____
Would anyone in your household benefit from treatment for abuse of Alcohol_____, Drugs_____, and/or Tobacco_____?

Check any conditions which your child has:

_____Asthma (Need asthma action plan from doctor

_____Diabetes (Need diabetes treatment plan from doctor)

_____Blood lead level >5µg/dl (Need result from doctor)

_____Hearing Problems_____

_____Hearing Aids? Left_____ Right_____

(PHYSICIAN DOCUMENTATION REQUIRED

Need allergy action plans for any severe allergies)

_____Allergy to Insects_____

_____Allergy to Food_____

_____Allergy to Medication_____

*** Make a copy of any information provided ***

_____Bleeding Difficulties (Need doctor order for limitations and treatment)

_____Seizures, Convulsions (Need seizure action plan from doctor)

_____Febrile Seizures (Need doctor order for guidance and treatment)

_____Vision Problems_____

_____Wears glasses? Yes_____ No_____

_____Heart condition_____ (Need dr order for limitations)

_____Use assistive devices? Circle: crutches, wheelchair, walker, braces

_____Has Epi Pen (Need allergy action plan from the doctor)

_____Other_____

Is your child taking any medications that will need to be administered by the school nurse during school hours? Yes_____ No_____
(Please Bring all necessary medications to the school, before starting)

If yes, what medications? _____

DISABILITIES SERVICES: *** Make a copy of any information provided ***

Do you suspect that your child has a disability or special need?	**Yes**_____	**No**_____
What type of disability does your child have?_____		
Has a professional assessed / diagnosed your child's disability?	**Yes**_____	**No**_____
Has your child received Early Childhood Intervention (ECI) services?	**Yes**_____	**No**_____
Do you have medical documentation or a school district Individual Education Plan (IEP)?	**Yes**_____	**No**_____
Does your child receive disabilities services from a community resource agency?	**Yes**_____	**No**_____

If yes, name of agency and type of service:_____

Child's Name:_____ **Date**_____

Behavioral / Wellness History	**Yes**	**No**	**If "Yes" is marked please explain**
Does your child have any problems sleeping?			Hours slept per night? _____ Naps per day? _____
Does your child have difficulty with toileting independently?			
Any difficulty with urination?			
Any frequent diarrhea / constipation?			
Does your child wear diapers / pull ups?			
Does your child get any indoor or outdoor physical play?			If yes, minutes per day?
Do you have any instructions for your child's teacher to help them understand your child's needs, attitudes, or behavior?			
Does your child have difficulties socializing with other children his/her age?			
Does your child have difficulties separating from parents/other adults?			
Have there been any major changes in your child's life in the last six months?			
Are you or your family having any problems now that might affect your child?			
Pregnancy / Birth History	**Yes**	**No**	**Explain "Yes" Answers (make a copy of physician notes, if needed)**
How far along in pregnancy were you when you went to the doctor?			_____Weeks _____Months _____Never went to the doctor
Were there any complications in pregnancy?			If yes, explain:
Any prenatal exposure to drugs, alcohol, caffeine or tobacco?			If yes, explain:
Any birth defects?			If yes, explain:
Where was your child delivered? Birth weight_____			____Hospital ____Birthing Center ____Home ____Don't know
How long were you and baby in the hospital?			Days for Mother_____ Days for Baby_____ Reason for any extended stay_____
Does the child have any birth problems or concerns that still affect them today?			

Intake Form 4
Child Nutritional Assessment

Child's Name_____ **Male**_____ **Female**_____ **DOB**_____ **Age**_____

School_____ **Head Start**_____ **Early Head Start**_____ **Date**_____

Nutritional History / Information	Yes	No	If "Yes" is marked please specify
Does your child have food intolerances/allergies?			What foods? **PHYSICIAN DOCUMENTATION REQUIRED**
Is your child on a special diet for: • Religious Beliefs **(If yes, parent must provide written instructions on religious dietary practices**) • Medical **(If yes, parent must provide written physician's instructions)**			Explain: **Head Start requires doctor's orders to provide special diet for allergies. All food provided by Head Start. No foods are to be brought in by parents.**
Breastfeeding? ☐ Not applicable			Feedings per day? _____ Minutes per feeding? _____
Bottle feeding? ☐ Not applicable Type of formula? _____			Feedings per day? _____ Ounces per feeding? _____ Brand of bottle used? _____ Type of nipple used? _____
Does your take a child vitamin/fluoride/mineral supplement?			Contains: ☐ Iron ☐ Fluoride ☐ Prescribed by a doctor
Child drinks water?			☐ Tap water ☐ Bottled water ☐ Well water
Child drinks what during the day with meals/snacks? ☐ Cup ☐ Sippy cup			☐ Milk ☐ Water ☐ Juice ☐ Kool-Aid ☐ Other_____ ☐ Lactose free milk (needs doctor order for school) ☐ Soy milk (needs doctor order for school)
Is your child a picky eater?			
Has your child's appetite changed in the past month?			
Does your child eat or chew things that are not food?			If yes, what?
Do you have any concerns about what your child eats?			
Does your child have trouble with: ☐ Sucking ☐ Chewing ☐ Swallowing ☐ Refusal of any food group What type of difficulty?			
Eating Frequency: Number of meals per day _____ Number of snacks per day _____			
Child's favorite foods?			
Child's least favorite foods or disliked foods?			

Consents and Permissions

Child Name: _____ DOB _____Family Name) _____
First MI Last

I hereby give my permission for the following:

***Head Start /Early Head Start*:**	***(Please initial in columns)*** Yes	No
Vision	_____	_____
Hearing	_____	_____
Heights and Weights	_____	_____
Mental Health Classroom Observation	_____	_____
Social/Emotional Well-Being - Devereux Early Childhood Assessment **(DECA/DECA I/T)**	_____	_____
Developmental Screening (Brigance) *for Head Start/Early Head Start*	_____	_____

Other Permissions/Releases:	***(Please initial in columns)***	
1) Child to accompany class on Field Trip	_____	_____
2) Release of ***parent*** name and contact information to parent committee officers for use obtaining help in school related projects.	_____	_____
3). Release of ***child name*** & ***photo*** –		
a. Social Media - (Facebook, Twitter, Instagram)	_____	_____
b. Newspaper / TV	_____	_____
c. Region 14 website	_____	_____
d. ESC Publications (Annual Report, Community Assessment, Flyers, Brochures)	_____	_____
e. Educational purposes (teacher trainings to include videotaping)	_____	_____
4) Other: Specify _____	_____	_____

Attendance Policy*(important)	***(Please initial in columns)***	
1) I will bring my child to school and be on time every day unless they are sick.	_____	_____
2) I understand that excessive absences or tardiness is considered when re-enrolling a child for EHS and HS.	_____	_____
3) I will notify the school if my child is sick or going to be late.	_____	_____

I understand the above consents and permissions.

Parent/Guardian Signature: _____

Print Parent/Guardian Name: _____ Date _____/_____/_____

Staff Signature: _____ Date _____/_____/_____

Print Staff Name: _____

This form is valid through the current school year