

UCAN Head Start/Early Head Start
2014-2015 Head Start Application
Cover Letter & Instructions
(Application is attached)



What is Head Start?

Head Start is a comprehensive **preschool** program serving families with low-income. Children receive education services to increase their school readiness. Parents are assisted in overcoming barriers to self-sufficiency. Head Start works with the entire family and offers all family members opportunities to develop to their full potential. We provide a positive, respectful environment for growth and awareness for both parents and children. UCAN Head Start serves families in communities throughout Douglas County with children ages 3 and 4 by Sept. 1, 2014.

What is Early Head Start?

Early Head Start is a **Home-Based** service which provides service through weekly home visits. The home visitor provides child-focused visits that promote the parents' ability to support the child's development. During the month, the program offers opportunities for parents and children to come together as a group for learning, discussion, and social activity. Parents are assisted in overcoming barriers to self-sufficiency. Early Head Start works with the entire family and offers family members opportunities to develop to their full potential. We provide a positive, respectful environment for growth and awareness for both parents and children. UCAN Early Head Start serves the families of pregnant moms and children aged zero-three in communities throughout Douglas County.

How to Apply for Head Start or Early Head Start

Please read this application carefully and fill it out completely. It contains important information that is used to determine if your child is eligible for Head Start/Early Head Start services and to prioritize and place your child on the waiting list for the classroom that serves your area. **If you are applying for more than one child, need help in completing the application, or have any questions, please call us at 541-673-6306.**

Keep this cover letter for quick access to our phone/fax and address.

What to Include with the Application

We MUST have the Starred documents listed below to process the application.

- ★ **INCOME:** We need proof of income in the form of W2s, Tax returns, pay-stubs or others listed on pg. 5 of application.
- ★ **PROOF OF BIRTH/Pregnancy:** Include birth certificate or other legal document *with the child's name and date of birth printed. If you a pregnant mother, please send a doctor's note or verification from the Health Dept. verifying pregnancy*
- ★ **SHOT RECORD:** Please send your child's shot record, it 's Head Start's expectation that all shots are up to date.

The items below may be returned at a later date. We are able to process the application without these items

- ➔ **Community Referral:** If a doctor, service agency or other has written a referral, please attach or have them send it in.
- ➔ **Dental/Medical Verification Form:** Included with application. Please complete & return or bring into our office for help.
- ➔ **Medical Diagnosis:** If the mother or child has been diagnosed with a chronic condition include the documentation.
- ➔ **Legal Documents:** For custody, power of attorney, restraining orders or any pertinent legal actions, send documents.

Please mail or drop the application off at 948 SE Roberts St., Roseburg, OR 97470

Or Fax to 541-492-1663. *Questions?* 541-673-6306/800-320-6306

What Happens Next?

When we receive your application:

- ➔ We will send you a confirmation of receipt
- ➔ We will review the application and let you know if we need more information.
- ➔ When we have an opening for your child, we will contact you by letter or phone call to arrange to complete the registration process.
- ➔ You should make sure that your child's Well Child/Baby Checks, Dental exams (HS only), and Immunizations are up to date

WE MUST BE ABLE TO REACH YOU!

If you move or change your phone number after completing this application, please notify us.

Submitting this application does not ensure enrollment.

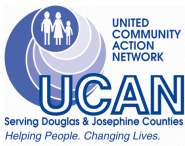
Applications are prioritized based on need.

**Please don't hesitate to call the office for help.
We can help you over the phone or set up an appointment
To help you fill this out one-on-one
541-673-6306**

[Si necesita una aplicación en Español, por favor llame al 541-391-3770](tel:541-391-3770)

Please mail or drop the application off at 948 SE Roberts St., Roseburg, OR 97470

Or Fax to 541-492-1663. *Questions?* 541-673-6306/800-320-6306



UCAN Head Start/Early Head Start 2014-2015 Application for Enrollment

948 SE Roberts St. Roseburg OR 97471 * 541-673-6306 / 800-320-6306 / FAX: 541-492-1663

Please fill out the form completely and accurately. All information will be kept confidential. Information is used to help us determine if your family is eligible for Head Start/Early Head Start services and to prioritize your application



Are you a pregnant woman applying for the program? YES NO High Risk Pregnancy

IF YOU ARE APPLYING FOR MORE THAN ONE CHILD, PLEASE CALL 541-673-6306 AND REQUEST AN ADDENDUM PAGE

General Information (the home in which this child/pregnant mom lives)

Living Address	Apt. #	City	State	Zip
OR				

Mailing Address (if different)	Apt. #	City	State	Zip
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Primary	Phone Number	Phone Type (HOME, CELL, WORK)
<input type="checkbox"/>		
<input type="checkbox"/>		

Statistical Information (For staffing purposes. The answer will not affect your status in the program or chance of acceptance)

Is a family member related to a UCAN Head Start/Early Head Start employee? N / Y, if yes, employee name _____

Child's Information/Pregnant Mother Information

Last	First	Middle
Date of Birth or child's due date / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> undetermined	<input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic or Latino Origin

Race (check all that apply) American Indian Asian Black/African American Multi/Bi-racial White
 Native Hawaiian/Pacific Islander Other _____

Is English the primary language of the child? Yes No List other language spoken _____

Does the child/Mother have health insurance? Yes No If no, may we contact you to discuss Cover Oregon? Y N
 If yes : OHP Private Insurance Name: _____ OHP or Insurance # (REQUIRED) _____

Doctor's Name: _____ Most current Visit ___/___/___ Next schedule d visit ___/___/___

Dentist's Name: _____ Most current Visit ___/___/___ Next scheduled visit ___/___/___

Child up-to-date on Immunizations? Y N Exempt Child is on WIC No Yes WIC # _____
 Please provide a **copy of the shot record**

**** It is Head Start/Early Head Start's expectation that your child is up-to-date on annual Dental Exams, Well Child/Well Baby Exams and immunizations prior to enrollment in Head Start ****

Release of Information (Please write your INITIALS in the yes or no box)

	YES	NO
I give consent for the applicant's education and health care providers (OHP, physicians, clinics, hospitals, dentists, specialists, community health nurses, WIC program, education cooperatives, school districts, preschool and daycare providers, Willamette Dental, Advantage Dental, DCIPA, DHS, Migrant Services, local county Health Department) to send all information pertaining to the immunization, health, dental and educational records of the applicant to UCAN Head Start/Early Head Start—948 SE Roberts St., Roseburg OR 97470 (I understand that UCAN Head Start/Early Head Start may also share information with the above providers)		

Parent/Legal Guardian— Living in the home with applied Child

Last	First	Middle	Birthday	Gender
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Relationship to Child _____ email address: _____

Highest Grade Completed (circle): 9or less
10th/11th/12th/HS Grad/GED/some college
college/Associate/Bachelors/Masters

Employment Status:

- Full Time Full time & training
 Part Time Part time & training
 Retired Disabled
 Training or School
 Seasonally Employed
 Stay at home Parent
 Seeking employment

Race:

- Asian White Bi-Racial
 Black or African American
 American Indian or Alaskan Native
 Native Hawaiian or other Pacific Islander

Ethnicity:

- Hispanic or Latino Origin
 Non-Hispanic or Latino Origin
 Does this person need a translator? Y / N

Marital Status: _____

English reading/writing Proficiency:

- None Poor Moderate
 Proficient

Other Language Spoken: _____

- Poor Moderate
 Proficient

**How did you hear about UCAN Head Start/
Early Head Start?**

Parent/Legal Guardian * Related by blood, marriage or adoption

Last	First	Middle	Birthday	Gender
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Relationship to Child _____ Same address as applied child? Yes No If No—please provide address and phone

Address _____ Phone Number _____

Highest Grade Completed (circle): 9or less
10th/11th/12th/HS Grad/GED/some college
college/Associate/Bachelors/Masters

Employment Status:

- Full Time Full time & training
 Part Time Part time & training
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 Native Hawaiian or other Pacific Islander

Ethnicity:

- Hispanic or Latino Origin
 Non-Hispanic or Latino Origin

English reading/writing Proficiency:

- None Poor Moderate
 Proficient

Other Language Spoken: _____

- Poor Moderate
 Proficient

Does this person need a translator? Y / N

Marital Status: _____

Custodial Information:

- Does not apply in my situation
 Sole Custody
 Joint Custody—both biological parents
 Joint Custody—other ; explain: _____
 Dual Custody (50/50)
 Physical Custody; explain who has legal custody

Foster Care; Caseworker Name _____

Is there a protection or restraining order regarding the child?

- No Yes (Please explain and **provide a copy** with the application)

Are there special visitation orders or Parenting Plan we should be aware of?

- No Yes (Please explain and **provide a copy** with the application)

Biological Parent— Not in the home of applied Child (Disregard if listed on pg.2)

Last	First	Middle	Birthday	Gender
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Relationship to Child _____ email address: _____

Address _____ Phone number _____

Highest Grade Completed: _____

Employment Status:

Full Time Full time & training

Part Time Part time & training

Retired Disabled

Training or School

Seasonally Employed

Stay at home Parent

Seeking employment

Race:

Asian White Bi-Racial

Black or African American

American Indian or Alaskan Native

Native Hawaiian or other Pacific Islander

Ethnicity:

Hispanic or Latino Origin

Non-Hispanic or Latino Origin

English Reading/Writing Proficiency:

None Poor Moderate

Proficient

Other Language Spoken: _____

Poor Moderate

Proficient

Does this person need a translator? Y / N

Marital Status: _____

A family is all people living in the same household who are supported by the income of the parent(s) or guardian(s) of the child applying to Head Start/Early Head Start and related to the parent(s) or guardian(s) by blood, marriage, or adoption

Family Members living in the household (include the applicant) (See explanation above)

Name	M / F	Birthdate	Relationship to Applicant	Language spoken/Race

Other Household Members (Not financially supported by applicant's parent/guardian, but living in the home):

Name	M / F	Birthdate	Relationship to Applicant	Language spoken/Race

Transportation (Head Start makes every effort to provide transportation to as many children as possible—Some families may live outside of our bus routes or live in areas where we have designated the classroom as Self-transport REQUIRING families to transport their child to and from school)

Would you be able to transport your child to and from school or a designated pick up point? (Does not pertain to EHS)

Yes No ,explain :

If my child is on a transportation route, I give permission for Head Start/Early Head Start to transport my child to and from school or EHS playgroup (parents accompany to EHS playgroup)

Parent Signature _____

If selected for transportation, please list your child's pick-up and drop-off address *Only one address will be used for transportation:*

Street address _____ Apt. # _____ City _____

This address is Home Daycare Other _____

Child/Family Circumstances—Fill this section out completely *pertaining to the biological family and/or current family*. (Foster parents may need to have the child's caseworker answer these questions)

Do you have concerns for your child in the areas of:

Speech Development Behavior Mental Health

Other _____ No Concerns

Child's primary language is NOT English and the child has a low level of English proficiency.

Is your child receiving Services or therapy for speech or a disability through Early Intervention or ECSE?

Yes No Provider _____

Is your child receiving services from another program? (mental Health, CDRC, FDC, NFP, Healthy Families Etc) Yes No

Name of other Program _____

Circle any that apply: Child/pregnant mom is **diagnosed** with:
 ADHD/ADD Asthma Diabetes Hearing/Vision Impairment
 Heart Condition Post-Natal Depression Seizure Disorder
 Traumatic Brain Injury Autism

Current Household member and/or biological parent diagnosed and/or under treatment for chronic mental or physical health concern (other than the child applying)

Name _____

Other chronic Illness _____

****Documentation of doctor's diagnosis is required with this application if applicable****

Condition _____

Past Conditions:

- A parent of the applied child was/is 18 yrs or younger at the birth of the child/Pregnant mother is 18 yrs or younger
- Child was exposed to drug/alcohol/tobacco during pregnancy
- Infant received low APGAR scores
- Child has previously attended a Head Start/EHS Program

Current Conditions (for the home the child is in NOW):

- Only one adult lives in the home.
- Family member is unemployed, seeking employment
- A parent/guardian is deployed by the military
- Parent in the home has less than High School Diploma or GED
- Child is in Foster Care (see section below)

Within the last two years my child/family(ies) have experienced:

- Returned from Foster Care Child abuse or Neglect
- Death of a loved one that affects the family Drug/alcohol abuse
- Domestic Violence Divorce/Separation Homelessness
- Incarceration/parole/prbation of a parent/guardian
- Necessary move between school districts due to temporary/seasonal employment in agricultural, forestry, or fishing industry

What is your current living arrangement/situation? Own

- Rent motel Subsidized Housing Shelter
- Live with others because I cannot afford/find housing
- Live with others by choice Campground
- Other: Specify _____

How long have you lived at this address? _____

Special Circumstances

We understand that sometimes there are circumstances that can dramatically impact your family or your child that you feel we need to consider when we are selecting a child for Head Start/Early Head Start. If there are circumstances you would like to be considered that are not already listed on this application, please provide a detailed explanation of the special circumstance:

DHS Involved Families Only: Caseworker Name _____

- Child is in Foster Care Family has a DHS protective services Intervention Plan
- You are the parent /guardian of the child being applied for who is under the jurisdiction of the court and in the legal custody of DHS
- Child is not in foster care, but is **not** living with a biological or adoptive parent and a caseworker is involved

Family Income (Mark all that apply)

Please mark if you receive: TANF ERDC SSI Please **provide a copy of award** letter for services

Name of Family Member working	Name of Employer?	How long working here?

As **Income Verification**, mark the copy you have included: W-2s Tax Return Pay Stubs (at least 1 mo.)
 Child Support case info Social Security Death and/or Disability Benefits letter Financial Aid award
 Unemployment Documentation Self-Employment statement of earnings Letter from employer
 Another form of income verification Explain _____

Statement of no Income: My family currently has no income last date income was received __/__/__
 My family has had no income for the past 12 months

Emergency Contacts Please list people below besides adults listed on page 2 that are allowed to pick up the child and we are able to contact in case of an emergency and release the child to if we are unable to get a hold of you. For your child’s safety the person listed below must be able to provide identification matching the name below when picking your child up.

1) Name: _____ Relationship: _____
 Phone: (____) _____ (____) _____ (____) _____
 Home Cell Cell Message Work

2) Name: _____ Relationship: _____
 Phone: (____) _____ (____) _____ (____) _____
 Home Cell Cell Message Work

My child is NOT to be released to the following individuals: _____
 (Please note: **Head Start/Early Head Start cannot keep a child from being released to a biological or legal parent without legal documentation in our files barring the release of the child to that individual**)

All applicants will receive confirmation of application and will receive an informational packet

Before submitting the application, please be sure to complete each section of the application and attach all applicable items marked in red. PROOF OF BIRTHDATE and/or PREGNANCY, PROOF OF INCOME , AND SHOT RECORD (if applying for a child) ARE REQUIRED TO PROCESS AN APPLICATION.

Affirmation:
 Under penalty of Perjury, I affirm that I am the parent or legal guardian of the child applying for Head Start/Early Head Start, and that to the best of my knowledge, all of the information that I have provided is complete and correct. I further understand that this is an application for services that are paid for with federal funds and that intentionally providing misleading, inaccurate or untruthful information of a material nature could result in disenrolling my child from Head Start/Early Head Start and could have serious legal consequences for me:
 _____ /____/____
 Parent/Guardian or *Case Worker’s Signature Date Signed
 (*If you are a FOSTER PARENT or DHS is the legal guardian, you will need to have the application signed by your caseworker)

“The US Department of Agriculture (USDA) and the State of Oregon prohibit discrimination in all USDA programs and activities on the basis of race, color, national origin, sex, religion, age, or disability”. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 14th and Independence Avenue SW, Washington, DC 20250-9410 or call 202-720-5964 or 888-271-5983 Ext. 516 (toll free). UCAN, USDA and the State of Oregon are equal opportunity providers and employers.

ORAL HEALTH ASSESSMENT

UCAN Head Start

948 SE Roberts St.

Roseburg, OR 97470

Fax: 541-492-1662

INSTRUCTIONS FOR PARENTS: If your child **has had a Dental Appointment within the last 12 months**, please take this form into the dental office to be completed. Return it to Head Start as soon as possible. *If this is a hardship, please bring this form into the Head Start office and we will be happy to assist you.* **OR** If your child **has NOT had a dental appointment within the last 12 mo.**, please make an appointment right away. Hold on to this form to be filled out and returned when the appointment is completed. *Please indicate within the application the dentist's name and appointment date.*

Child's Name _____

Date of Birth _____

Site _____

OHP # _____

DCO _____

Private _____

None _____

Most recent Date of last visit _____

No Treatment Needed (Child is up to date with care)

Treatment Indicated Approximate number of appointments needed _____

Treatment in Progress Next scheduled appointment _____

Child approved for fluoride Yes No

Applied _____

Applied _____ Applied _____

Did Child receive preventive care (Fluoride varnish or cleaning)?

Yes _____ No _____

ASTDD/Basic Screening Survey indicators:

Child has cavities: Yes No

Child has treated decay (fillings) Yes No

Child has ECC (current or past decay in upper anterior teeth): Yes No

Treatment Urgency:

0 No obvious problems

1 Early Dental Care needed

2 Urgent Care needed (pain/infection)

Comments: Needs / Dates

Fillings _____

Silver Nitrate _____

Other Treatment _____

Treatment (circle one) complete incomplete

Name of Dentist/Clinic _____ Phone: _____

Signature of Dentist: _____ Date: ____/____/____

UCAN HEAD START
948 SE Roberts St.
ROSEBURG, OREGON 97470
(541) 673-6306 FAX (541) 673-3236

Verification of Well Child / Well Baby Exam

INSTRUCTIONS FOR PARENTS: If your child **has had a WCE within the last 12 months**, please take this form into the doctor's office to be completed. Return it to Head Start as soon as possible with chart notes. *If this is a hardship, please bring this form into the office listed above and we will be happy to assist you.*

OR

INSTRUCTIONS FOR PARENTS: If your child **has NOT had a WCE within the last 12 mo.**, please make an appointment right away. Hold on to this form to be filled out and returned when the appointment is completed or bring into registration appointment upon selection into Head Start. *Please indicate within the application the Dr. name and appointment date.*

Child's Name: _____ Parent's Name: _____

Name of Physician: _____

Date of most current Well Child/Well Baby Exam: _____ (**Physician use only**)

Please check all that apply:

Needs no follow up related to the WCE at this time

Chart note attached

Needs a Well Child/ Well Baby examination in the month of ____

Needs the following services i.e., lab tests, referrals ____

Needs accommodations in school, please list ____

Next WCE Appointment scheduled for ____

Signature of Primary Care Provider _____ Date _____

Head Start Office use only:

Entered in Web database

Follow up needed

UCAN Head Start
948 SE Roberts St.
Roseburg, OR 97470
2014/2015

