



UCAN HEAD START 2010/2011 Head Start Application
511 W. Umpqua Roseburg, OR 97471 (541) 673-6306 / 800-320-6306 / FAX: (541) 492-1663

UCAN Head Start provides a pre-school education, comprehensive social services and nutritious meals to low-income 3 and 4 year old children and their families at no cost.
(To be considered for the school year listed above your child must have turned 3 by September 1, 2010.)

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

If you have any questions about this application, or need any help in completing it, please contact us. **We will be glad to help!**

Child's Name: _____
(First) (MI) (Last)

SSN# _____ - _____ - _____ School District of Residence _____ Male Female

Date of Birth: ____/____/____ **(Attach copies of proof of birth: birth certificate, hospital documentation, or court document)**

Medical Insurance Information: OHP # _____ Other health insurance Name: _____ # _____
 No Health Insurance – To sign-up for OHP contact UCAN Healthy Kids program: 541-492-3907 or 800-301-8226

Ethnicity: Non-Hispanic/Non-Latino Hispanic or Latino – Mexican Hispanic or Latino (other) _____

Race: White American Indian or Alaskan Native Asian Biracial/Multi-Racial Black or African American
 Native Hawaiian or Other Pacific Islander Other _____

Primary Language English Spanish Other _____ Secondary Language Spanish Other _____

Is this child a Dual Custody child Yes No List any custodial issues or other safety items that we should be aware of: _____

Parent/Guardian (Foster Parents and parents with children under the jurisdiction of the state fill in caseworker information on the next page and have the caseworker sign the application.)

1) Name: _____ SSN# _____
(First) (MI) (Last)

Relationship to child: _____ (mother, father etc.) Marital Status: _____ Date of Birth: ____/____/____

Educational Level: High School Graduate GED Highest Grade Completed (K-12) _____
 College- Type of degree or years attended: _____

Occupational Status: Full Time Part Time Seasonal Unemployed Retired School/Training Other _____

Training Status: No Training School Training Work/Training

Primary Language English Spanish Other _____ Secondary Language Spanish Other _____

Does this person need a translator yes / no

Mail: _____
(Address) (City) (Zip)

Home (if different) _____
(Address) (City) (Zip)

Telephone: (____) _____ - _____ (____) _____ - _____ (____) _____ - _____ Email Address _____
 Home / Cell Work Cell / Message

Parent/Guardian continued

2) Name: _____ SSN# _____
(First) (MI) (Last)

Relationship to child: _____ (mother, father etc.) Marital Status: _____ Date of Birth: ____/____/____

Educational Level: High School Graduate GED Highest Grade Completed (K-12) _____
 College- Type of degree or years attended: _____

Occupational Status: Full Time Part Time Seasonal Unemployed Retired School/Training Other _____

Training Status: No Training School Training Work/Training

Primary Language English Spanish Other _____ Secondary Language Spanish Other _____

Does this person need a translator yes / no

Mail: _____
(Address) (City) (Zip)

Home (if different) _____
(Address) (City) (Zip)

Telephone: (____) _____ - _____ (____) _____ - _____ (____) _____ - _____ Email Address _____
 Home/ Cell Work Cell / Message

If you are a Foster Parent or parent with children under the jurisdiction of the court and placed in the legal custody of the Department of Human Services you will need to have the application signed by your caseworker)

Caseworker Name: _____
(First) (MI) (Last) (Phone) (Email)

I am employed by or related to an employee of UCAN Head Start. yes no
If yes – Name of employee _____

How/where did you find out about Head Start? _____
If you have been referred from a community agency please obtain a written referral from the agency that referred you.

Does your child need a ride to school yes no Does your child need a ride home yes no
If yes please explain _____

Please only mark “yes” if you absolutely cannot transport your child to and from school. 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 a self transport classroom requiring families to transport their child to and from school.

Alternate address for transportation and center assignment (ex. Childcare address, other parent’s house, etc)
Caution: If you put an alternate address down in this section we will place your child on the classroom list that serves that area.

Name (child care provider/other parent etc) (Address) (City) (Zip) Phone #

Days and times child is at alternate address (ex. Monday-Thursday 10am-2pm) _____

Family Size

Please list all people in the household if you need more room, use another sheet of paper.
(Foster Families list only the child you are applying for)

Name (First, MI, Last)	Date of Birth	Relationship to Child	**see question below
1) _____	____/____/____	<u>Applied Child</u>	<input type="checkbox"/> Yes/ <input type="checkbox"/> No
2) _____	____/____/____	_____	<input type="checkbox"/> Yes/ <input type="checkbox"/> No
3) _____	____/____/____	_____	<input type="checkbox"/> Yes/ <input type="checkbox"/> No
4) _____	____/____/____	_____	<input type="checkbox"/> Yes/ <input type="checkbox"/> No
5) _____	____/____/____	_____	<input type="checkbox"/> Yes/ <input type="checkbox"/> No

**Is this person supported by the income of the parent(s) or guardian(s) of the child enrolling in the program and related to the parent(s) or guardian(s) by blood, marriage, or adoption.

Family Income

(Attach copies of income verification)

The documentation you provide must represent the total income of all members of the family who fit the ** question above for either the past twelve months or for the previous calendar year, which most accurately reflects your family's current financial situation. W-2, Tax Return, Pay Stubs, Unemployment, Child Support, Social Security Death and Disability Benefits, SSI Benefits, Financial Aid Award Letter, Self Employment, statement of earnings, Declaration of Homeless Status, TANF (Temporary Assistance to Needy Families), ERDC (Employment Related Day Care).

I have had no income over the past 12 months or from _____ to _____. My basic needs such as housing, utilities, etc. were met in the following way: _____

Is your family currently receiving any of the following services?

Food Stamps TANF (Temporary Assistance to Needy Families) WIC Public Housing Assistance
 Energy Program Assistance ERDC (Employment Related Day Care) Other Assistance: _____

For help with obtaining food stamps please call 1-800-723-3638.

To find out if you are eligible for Food Stamps, OHP or other assistance go to www.oregonhelps.org

Mark one or both if applicable:

- The following description has applied to my child and/or family's situation sometime during the past 2 years and/or
 The following description represents my child and/or family's current situation:

McKinney-Vento Act

A child or family who lacks a fixed, regular, and/or adequate nighttime residence.

This includes families who:

- 1.) Are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason.
- 2.) Are living in motels, hotels, trailer parks, or camping grounds due to the lack of adequate accommodations.
- 3.) Are living in emergency or transitional shelters
- 4.) Are abandoned in hospitals
- 5.) Are awaiting foster care placement
- 6.) Have primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings
- 7.) Are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings
- 8.) Migrant children and youth who are living in circumstances described above.

(*A **fixed residence** is one that is stationary, permanent, and not subject to change. *A **regular residence** is one that is used on a nightly basis. *An **adequate residence** is one that is sufficient for meeting both the physical and psychological needs typically met in home environments.)

If you are a foster parent or other guardian answering the questions on this page please answer the questions pertaining to the family in which the child came from. You 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

If marked is your child eligible for or on an IFSP and/or receiving services? Yes No

Child Diagnosed with a Medical or Biological Issues such as: ADHD/ADD, Asthma (requiring medication), Diabetes, Hearing/Vision Impairment, Heart Condition, Seizure Disorder (requiring medication), Traumatic brain injury, or other chronic illness

(documentation of doctors diagnosis required with this application if applicable)

Another agency has referred your child to Head Start (Written referral required with this application if applicable)

Has your child had a Well Child Exam within the last year?

yes / no

(A Well child exam is not visit to Doctor because child was sick)

If yes date of exam ____/____/____

If you answered no please call and schedule an appointment right away. Date of the scheduled appointment ____/____/____

Doctor Name _____

It's Head Start's expectation that your child is up-to-date on Annual Well Child Exams and immunizations prior to Enrollment.

Is your child up to date on state required immunization to enter preschool yes / no If you answered no please call and schedule an appointment right away.

Please provide copy of your child's current immunization record with this application. Once your child's immunizations are up to date please send us a copy of the updated record.

It's Head Start's expectation that your child is up-to-date on immunizations prior to Enrollment.

Has your child had a Dental Exam within the last year?

yes / no

If yes Date of Exam ____/____/____

If you answered no please call and schedule an appointment right away. Date of the scheduled appointment ____/____/____

Dentist Name _____

It's Head Start's expectation that your child is up-to-date on Annual Dental Exam prior to Enrollment.

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

If this item is marked is the child on an IFSP for speech

yes / no

Child is in foster care

You are the parent or guardian of the child being applied for who is under the jurisdiction of the court and in the legal custody of the Department of Human Services

Child is not in foster care, but is **not** living with a biological or adoptive parent

Family has a DHS Protective Services Intervention Plan Caseworker _____

Only one adult lives in the home

Household member diagnosed and/or under treatment for chronic mental or health concern (other than child applying for)

Name _____

Please describe _____

Parent in home with less than a High School Diploma or GED

Military deployment

Child abuse or neglect within the past two years

Death in the family within the past two years

Divorce/Separation within the past two years

Drug or alcohol abuse within the past two years

Domestic violence within the past two years

Incarceration of a parent or guardian within the past two years

English proficiency in speaking, reading, or writing of the adult members of the family:

Low Med High

You were 18 years or younger at the birth of this child

Household member laid off due to a company cut back or shut down within the last year.

My family does not have access to a reliable ongoing source of transportation

My family does not have access to affordable, reliable, quality childcare

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 the program. If there are circumstances you would like to be considered that are not listed already on this application, please provide a detailed explanation of the special circumstance:

Child Health Record

In the last year, has the child had any of the following conditions (please check all that apply):

- Allergies Diabetes High Lead Asthma Tubes in ears Heart Conditions Seizures
- Other _____

Please comment on any checked conditions _____

Is the child receiving treatment for any of the following (please check all that apply):

- Anemia Asthma Overweight Hearing Difficulties Vision Problems High Lead Levels
- Diabetes Other _____

Is the child currently taking any medications Yes/ No

If yes Name of Medication: _____ Dose _____ How often/when? _____
 Name of Medication: _____ Dose _____ How often/when? _____

If your child has a health problem has it been diagnosed by a doctor or health care professional. Yes/ No

If yes, please explain. List the name/address of the doctor/specialist: _____

Has the child ever had surgery Yes/ No If yes please explain _____

Has the child ever has a seizure Yes/ No If yes please explain how often, cause (if known), and _____

Date of last seizure ____/____/____

Has the child ever been diagnosed with asthma Yes/ No

If yes please explain how often, cause (if know), and date of last asthma attack _____

If yes, has the child ever been hospitalized for asthma Yes/ No When _____ Intensive Care(ICU/PICU) _____

Has the child ever had an allergic reaction Yes/ No If yes please explain to what _____

Please explain the reaction _____

Has the child ever had problems with the following conditions (please check all that apply):

- Frequent Ear Infections Frequent Fevers Frequent Chest Pains Problems Hearing
- Frequent Trouble Sleeping Frequent Sore Throats Frequent Cough Frequent Colds
- Problems Eating Problems with Seeing Speech Problems Frequent Bed-wetting
- Frequent Stomach Ache Problems with Teeth Eye Problems Temper Tantrums
- Problems with Urine Other Frequent Problems _____

Has the child ever been involved in a child abuse or neglect incident or case? Yes/ No

If yes please explain _____

Does your child have any additional conditions that interferes with his/her daily activities Yes/ No

If yes please explain _____

Nutrition Assessment/Survey

Is your child currently taking a vitamin supplement Yes/ No If yes is it iron fortified Yes/ No

If yes are they prescribed Yes/ No Name _____

Persistent/Current Nausea or Vomiting Yes/ No

Persistent/Current Diarrhea Yes/ No

Persistent/Current Constipation Yes/ No

Dramatic weight change in the past year Yes/ No

Recent surgery (within 3 months) Yes/ No – Type of surgery _____

Recent hospitalization (within 3 months) Yes/ No – For _____

Is your child on any special diet Yes/ No – What diet _____

Does your child have any food allergies or intolerance Yes/ No – if yes what foods _____

Do you have any other nutritional concerns Yes/ No If yes what are the concerns _____

Is your child participating in any nutrition programs Yes/ No Check all that apply WIC Food Stamps Other _____

Does your child have trouble swallowing Yes/ No

Does your child use a spoon or fork Yes/ No

Does your child use a feeding tube or other special feeding method Yes/ No

Do you think your child is too Thin Small Heavy Tall

Does your child currently take a bottle Yes/ No

Does your child eat or chew anything that is not food Yes/ No

Family Services Assessment

Do you receive publicly subsidized childcare through an agency Yes/ No

Do you receive childcare at a private daycare center or home Yes/ No

Do you receive childcare at the home of a relative or unrelated adult during non-Head Start hours Yes/ No

Do you need part-time childcare Yes/ No

Do you need full-time childcare Yes/ No

Do you have other daycare arrangements Yes/ No _____

Permission

Please check items below indicating permission granted for us provide screenings for your child, publicize your child picture, etc.

- Behavioral Screening
- Developmental Screening
- Hearing Screening
- Publicity
- Sun block Application
- Vision Screening
- Class Directory Listing
- Field Trip Attendance
- Height and Weight measurements
- Speech Screening
- First Aid

Emergency Contact Information

Please list all people below beside adults listed on first page of the application that are we are allowed pick the child up after school 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 when picking your child up. Please use legal name listed on person's identification.

1) **Legal Name:** _____
(First) (MI) (Last)

Home _____
(Address) (City) (Zip)

Telephone: (____) _____ - _____ (____) _____ - _____ (____) _____ - _____
 Home/ Cell Work Cell / Message

2) **Legal Name:** _____
(First) (MI) (Last)

Home _____
(Address) (City) (Zip)

Telephone: (____) _____ - _____ (____) _____ - _____ (____) _____ - _____
 Home/ Cell Work Cell / Message

Emergency Contact Information Continued

3) **Legal Name:** _____
(First) (MI) (Last)

Home _____
(Address) (City) (Zip)

Telephone: (____)_____-____-____ (____)_____-____-____ (____)_____-____-____
 Home/ Cell Work Cell / Message

4) **Legal Name:** _____
(First) (MI) (Last)

Home _____
(Address) (City) (Zip)

Telephone: (____)_____-____-____ (____)_____-____-____ (____)_____-____-____
 Home/ Cell Work Cell / Message

Preferred Hospital: _____ Address _____

My child is NOT to be released to the following individuals _____

I hereby give my authority to UCAN Head Start Staff to obtain necessary Emergency Medical and/or Dental treatment for my child with understanding the family will be notified as soon as possible

I DO NOT give my permission for UCAN Head Start Staff to obtain Emergency Medical and or Dental treatment for my child. I will accept full responsibility to obtain treatment.

Before submitting the application please be sure to attach all applicable items that are highlighted in yellow. Proof of child's birth date and proof of family income is required in order to process an application.

All applicants will be notified of the child's potential placement after the application has been processed.

Affirmation

Under penalty of perjury, I affirm that I am the parent or legal guardian of the child applying for Head Start, and that, to the best of my knowledge, all of the information that I have provided is complete and correct.

I authorize Department of Human Services, Education Service District/EI&ECSE, Douglas County Health Department/Mental Health, Family Development Center, Healthy Kids Program, the doctor or dentist listed on this application, and the foster parent, or parent whose child is under the jurisdiction of the court, and placed in the legal custody of the Department of Human Services listed on the application, to share and exchange information and records about me and my family with UCAN Head Start, and for UCAN Head Start to share and exchange information and records about me and my family with these individuals or agencies. (Please cross off any that you do not give us permission to exchange information with)

_____/_____/_____
Parent/Guardian or Case Worker's Signature Date Signed

If you are a Foster Parent or parent with children under the jurisdiction of the court and placed in the legal custody of the Department of Human Services you will need to have the application signed by your caseworker)

“The U.S. 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 Extension 516 (toll free). USDA and the State of Oregon are equal opportunity providers and employers.”

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