



UCAN HEAD START 2011/2012 Head Start Application Instructions – Application is attached

511 W. Umpqua Roseburg, OR 97471
 (541) 673-6306 / 800-320-6306 / FAX: (541) 492-1663

Head Start is a comprehensive pre-school 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.

| Benefits of Head Start | |
|---|--|
| For Parents | For Children |
| <ul style="list-style-type: none"> • Direct involvement in the education of their child • Positive home-school relationship through center activities and Family Partnership Meetings • Adult education and training sessions and information • Increased knowledge of community resources • Enhanced self esteem • Involvement in decision making at Head Start • No charge for Head Start services | <ul style="list-style-type: none"> • Individual education plan for each child • Rich social environment • Challenging experimental activities • Lasting gains in school performance • Nutritious meal program • Medical, dental, vision, hearing, speech screenings • Enhanced self esteem • Outdoor activities increase child's physical health |

General Instructions:

- 1) Fill out each section completely. There is a checklist with instructions on the back of this sheet – you don't have to return this first sheet.
- 2) Information regarding **Foster Children is highlighted in Blue** on this sheet and the application.
- 3) If a question doesn't relate to you please use "n/a" for the answer – for example – if you do not have a cell/message phone, mark "n/a" rather than leaving it blank (this way we know that you haven't overlooked a particular question)
- 4) If you leave any sections blank, it may lower the chances of your child being selected
- 5) Be sure to attach all items that pertain to your family situation which are **highlighted in yellow** on this form and the application. Failing to attach these items will delay the process of application.
- 6) You may mail in the application, bring it in to any Head Start classroom or the main office listed above, or fax it to the number above
- 7) You will receive notification whether or not your child has been selected through the mail or by phone.

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

| Item to attach | Possible items include: | Check if attached |
|---|--|--------------------------|
| Proof of Birth | birth certificate, hospital documentation or court document that shows the child's birth date. | |
| Income Verification | W-2's, tax return, pay stubs, Child Support award unemployment documents, Social Security Death or disability award, SSI Benefits letter, Financial Aid award, letter from employer stating your income, Self-employment statement of earnings, TANF award – other form of income verification for the calendar year or the past 12 months | |
| Immunization Record | Printout from the doctor, personal record of immunizations administered, Oregon Immunization alert form. | |
| Medical/ Dental Verifications | Enclosed with this application is a form to take into your providers. Please have them fill out and return with the application. If you have not yet had an appointment, please make an appointment and include the date on the form. | |
| Community Agency Referral letter | If an agency has given you a referral letter, please attach it to the application, or they may send it to us or fax it to our office (the address and fax number can be found above) | |
| Documentation From a Doctor | If the child has been diagnosed with a medical or biological issue, make sure to include the documentation that shows that diagnoses. | |
| Legal Documents | If there is custody, power of attorney, legal adoption, restraining orders or any other pertinent legal documents please attach with the application | |

| Section # | Instructions/Clarifications | Check when completed |
|---|---|----------------------|
| Section 1 (Child Information) | *The child's legal name needs to be on the application – no nicknames – it needs to be the same as shown on the proof of birth *To be considered for the school year listed above your child must have turned 3 by Sept. 1, 2011. *Proof of Birth (birth certificate, hospital documentation or court document) must be included. *If the child is in foster care, under a protective Intervention plan, or under the jurisdiction of the court, we must have the caseworker's name. To sign-up for OHP contact UCAN Healthy Kids program: 541-492-3907 or 800-301-8226 | |
| Section 2 (Parent/Guardian Information) | *If you are the legal guardian, but not mother/father, please indicate your relationship after your name -for example John Smith (Grandfather) or Ann Jones (foster mother). *We will base classroom assignment on the home or daycare address *Fill this section out as completely as possible. | |
| Section 3 (Family Size) | *List everyone living in the home, including you. *Mark yes if the 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. *Foster families, only list the child you are applying for. | |
| Section 4 (Statistical Information) | *For staffing purposes, we ask that you let us know about any relationship with a Head Start Employee. *The answer will not affect your status in the program or your chance of acceptance. *If you were referred by a community agency (Doctors, teachers, Early Intervention etc.) please include the referral letter (or have them send it into our office) | |
| Section 5 (Transportation) | *If you put an alternate address down in this section we will place your child in the Classroom that serves that area, upon selection. *If your home address and your alternate address are served by different classrooms, we will only travel to one address if the child is bussed. *The drop off and pick up time in the alternate address chart is the time that you drop off and pick up your child from that address. | |
| Section 6: (Family Income) | *The income documentation you provide must represent the total income of all members of the family who fit the definition for family size for either the past twelve months or for the previous calendar year, whichever most accurately reflects your family's current financial situation. Foster families need not send in financial information. *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 | |
| Section 7: (Child/Family circumstances) | *Please answer these questions as they pertain to your child/family * Foster families should answer for the Child's biological family (except where noted) – caseworkers can help you answer the questions **Include immunization records, Medical Verification and Dental Verification with the application. If the child has been diagnosed with a medical or biological issue also include documentation from the doctor | |
| Section 8: (Child Health Record) | The answers you provide in this section will be included in the child's records at Head Start upon selection. If you have any questions, please contact our office | |
| Section 9: (Nutrition Assessment/ Survey) | The answers you provide in this section will be included in the child's records at Head Start upon selection. If you have any questions, please contact our office | |
| Section 10: (Family Services) Assessment | The answers you provide in this section will be included in the child's records at Head Start upon selection. If you have any questions, please contact our office | |
| Section 11: (Permissions & Authorizations) | The answers you provide in this section will be included in the child's records at Head Start upon selection. If you have any questions, please contact our office | |
| Section 12: (Emergency Contact Information) | *List the names of people who you will allow to pick up your child in your absence or who we may contact in the case that we could not get in touch with you. *If you would like to add more than we have given room to, you may add another sheet of paper * Please note: 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 from that individual. You may include this with the application or bring it in personally. | |
| Section 13: (Parent/Guardian Signature) | *Before signing and submitting the application please be sure to complete each section on the instruction sheet and 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. *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 | |

Please call 541-673-6306 for any questions – we will be happy to help you!!

UCAN HEAD START
511 Umpqua Street
ROSEBURG, OREGON 97471
(541) 673-6306 FAX (541) 673-3236

Verification of Dental Treatment

Child's Name: _____

Parent's Name: _____

Name of Dentist: _____

Date of most current Dental Exam: _____ **(Dental office use only)**

Needs no treatment at this time

Needs the following services _____

Appointment scheduled for _____

Signature of Dentist _____ Date _____

Head Start Office use only:

Entered in GE Classroom _____ Follow up by FSE needed

UCAN HEAD START
511 Umpqua St.
ROSEBURG, OREGON 97471
(541) 673-6306 FAX (541) 673-3236

Verification of Well Child Exam

Child's Name: _____

Parent's Name: _____

Name of Physician: _____

Date of most current Well Child: _____ (**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 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 GE Classroom _____ Follow up by FSE needed



UCAN HEAD START 2011/2012 Head Start Application

511 W. Umpqua Roseburg, OR 97471 (541) 673-6306 / 800-320-6306 / FAX: (541) 492-1663

Please fill in the form completely and accurately. All 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.

Section 1 (Child Information)

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

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

Date of Birth: ____/____/____ **(Attach copies of proof of birth)**

Medical Insurance Information: OHP # _____ Other health insurance Name: _____ # _____
 No Health Insurance

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: _____

Is this child in foster care/jurisdiction of the court? Yes No. If - **Yes:** Caseworker name _____
 Caseworker phone # _____

Section 2 (Parent/Guardian Information) PLEASE list information for both parent/guardians, regardless of residence

| | | | |
|---|--|---|--|
| Mother's Name | | Father's Name | |
| SSN | | SSN | |
| Marital Status | | Marital Status | |
| Home Phone | | Home Phone | |
| Work Phone | | Work Phone | |
| Cell/message ph. | <input type="checkbox"/> cell <input type="checkbox"/> msg | Cell/message Phone | <input type="checkbox"/> cell <input type="checkbox"/> msg |
| Mailing Address City, State, Zip | | Mailing Address City, State, Zip | |
| Home Address, if different | | Home Address, if different | |
| Child lives here? | <input type="checkbox"/> yes <input type="checkbox"/> no | Child lives here? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Educational Level | <input type="checkbox"/> High School Graduate <input type="checkbox"/> GED <input type="checkbox"/> Highest Grade completed (k-12) <input type="checkbox"/> College-type of degree or yrs. | Educational Level | <input type="checkbox"/> High School Graduate <input type="checkbox"/> GED <input type="checkbox"/> Highest Grade completed (k-12) <input type="checkbox"/> College-type of degree or yrs. |
| Occupational Status | <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> School | Occupational Status | <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> School |
| Training Status | <input type="checkbox"/> No Training <input type="checkbox"/> School <input type="checkbox"/> Training <input type="checkbox"/> Work/training | Training Status | <input type="checkbox"/> No Training <input type="checkbox"/> School <input type="checkbox"/> Training <input type="checkbox"/> Work/training |
| Primary Language | | Primary Language | |
| Other language | | Other Language | |
| Does this person need a translator | <input type="checkbox"/> yes <input type="checkbox"/> no | Does this person need a translator | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Email address | | Email address | |

Section 3 (Family Size)

Please list **ALL** of the 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) _____ | ____/____/____ | Applied Child | <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 |
| 6) _____ | ____/____/____ | _____ | <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.

Section 4 (Statistical Information)

For staffing purposes, we are asking the following question.

The answer will not affect your status in the program or your chance of acceptance:

A member of our household is employed by or related to an employee of UCAN Head Start. yes no

If yes – Name of employee _____

Nature of relationship _____

How/where did you find out about Head Start? _____

Were you referred by a community Agency yes no (please include a written referral from the agency that referred you.)

Name of agency _____

Section 5 (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 a Self- transport classroom *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? yes no If no, please explain why:

If my child is on the transportation route I give permission for Head Start to transport my child to and from school. yes no

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)

Phone number(s) (City) (zip)

Days and times child is at alternate address:

| Day | Monday | Tuesday | Wednesday | Thursday |
|------------------|--------|---------|-----------|----------|
| Time dropped off | | | | |
| Time picked up | | | | |

(Attach copies of income verification) Attach all copies of income verification which apply for the past 12 months or previous calendar year, whichever most accurately reflects your family's current situation

- I have attached W-2's or Tax returns I have attached Pay Stubs I have attached Unemployment documentation
- I have attached Child Support case info. I have attached Social Security Death and Disability Benefits or SSI Benefits letter
- I have attached Financial Aid Award Letter I have attached Self Employment statement of earnings
- I have attached another form of income verification, please explain _____

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: _____

Please read the following to determine if this definition fits your family's situation currently or within the last two years:

McKinney-Vento Homelessness Act (definition)

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.)

Mark one or both if applicable:

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

Section 7: (Child/Family circumstances)

If you are a **foster parent** or other guardian answering the questions on this page please answer the questions **pertaining to the biological family**. 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)

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

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) Complete Medical Verification form filled out and signed by your child's primary care provider – RETURN WITH THE APPLICATION Doctor Name _____

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

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

- yes / no Complete Dental Verification form filled out and signed by your child's dental provider – RETURN WITH THE APPLICATION Dentist Name _____

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

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)

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

Child was in foster care within the last two years, but is currently **not** 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** name _____

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

A parent/guardian is deployed by the military

Within the last two years my family has experienced:

- Child abuse or neglect Death in the family Divorce/Separation Drug or alcohol abuse Domestic violence Incarceration of a parent or guardian Necessary move between school districts due to temporary or seasonal employment in the agricultural, forestry, or fishing industry

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

- Low Med High

A parent of applied child was 18 yrs or younger at the birth of the child

Child was exposed to drug/alcohol/tobacco during pregnancy

All families, including foster families, please answer the following questions regarding your CURRENT situation

Household member currently unemployed

Only one adult lives in the home

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:

Section 8: (Child Health Record)

In the last year, has the child been diagnosed with 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 _____

Section 9: (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

Section 10: (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 _____

Section 11: (Permissions & Authorizations)

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

- | | |
|---|---|
| <input type="checkbox"/> Class Directory Listing | <input type="checkbox"/> Screening - Behavioral |
| <input type="checkbox"/> Field Trip Attendance, including Transportation by Head Start | <input type="checkbox"/> Screening - Developmental |
| <input type="checkbox"/> First Aid | <input type="checkbox"/> Screening - Speech |
| <input type="checkbox"/> Height & Weight Measurements | <input type="checkbox"/> Sun block application |
| <input type="checkbox"/> Learn about personal safety | <input type="checkbox"/> Transportation to a medical facility in the event of a medical emergency. |
| <input type="checkbox"/> Publicity – child | |
| <input type="checkbox"/> Publicity - family | |

I authorize the following agencies/individuals 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.

- 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,

Caseworker initial if 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 may share and exchange information and records about the foster child UCAN with Head Start and with the above individuals or agencies.

Please sign if this pertains to you: I am interested in having a representative of Healthy Kids contact me with information about Health Insurance for my child and/or family and give UCAN Head Start Permission to share my contact information with that program

Healthy Kids permission- parent signature _____

UCAN Head Start
511 W. Umpqua
Roseburg, OR 97471
2011-2012

