HHWP CAC Head Start
2022-2023 Application

Child's Name ____ **Sex** M or F **Birthdate** ____________
(First Middle Last)

Address ____________________________________ **PO Box** _______ **City** _____________ **Zip** ___________

County _____________________________ **Phone** ____________________________ Accept texts ☐ Yes ☐ No

What language does this child speak at home?____

Preferred Site: Findlay: _____ Full Day _____ Half Day
Kenton: _____ Full Day ______Half Day
Upper Sandusky: _____ Full Day ______Half Day
Forest: _____ Full Day
Ottawa: _____ Full Day
Leipsic: _____ Full Day

_____ Initial
No bussing for Findlay Full Day, Kenton Full Day, Forest, Ottawa, Leipsic and Upper Sandusky
Possible bussing for Findlay Half Day and Kenton Half Day

Who has legal custody of this child? ____

Are there custody, visitation, or foster care court orders for this child? ☐ Yes ☐ No (If yes, copy is needed)

Were parents legally married when this child was born? ***(Affects custody)*** ☐ Yes ☐ No

Child's Parents/Guardians are now: __Married __ Divorced __ Separated __Widowed __ Living Together __ Single Parent

List all people in your home:

Name	Date of Birth	Relationship to Custodial Parent/Guardian(s)

What is the best time to contact you? ____

Alternate or Emergency Contact:

Name	Address	Phone	Relationship

How did you hear about Head Start? ____

Has this child ever attended a different Head Start Program or other preschool? ____________________________

☐ File Exists

Parent/Guardian's Name ____ DOB ________________

____Biological ____ Adopted _____ Foster _____ Guardian _____ Other ________________________ ____Male _____Female

Home Address ____ Phone __________________

E-Mail Address ____ Accept emails ☐ Yes ☐ No
Preferred Method(s): ___Text ___Email ___Cell

Which languages can you: Speak __________________ Understand _______________ Read ______________

Primary language spoken at home ____

Employer ___________________________________ Full Time/Part Time Phone ____________________

Check highest completed: ___Less than HS diploma ___HS diploma/GED ___ Some college
___Associate's Degree ___Bachelor's Degree ___ Master's Degree

Are you currently in school or training? ☐ Yes ☐ No

Parent/Guardian's Name ____ DOB _______________

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Preferred Method(s): ___Text ___Email ___Cell

Which languages can you: Speak __________________ Understand _______________ Read ____________

Primary language spoken at home ____

Employer _______________________________________ Full Time/Part Time Phone _________________

Check highest completed: ___Less than HS diploma ___HS diploma/GED ___ Some college
___Associate's Degree ___Bachelor's Degree ___ Master's Degree

Are you currently in school or training? ☐ Yes ☐ No

Step-Parent Name ____ DOB ___________________

Cell Phone: _____________________________________ Preferred Method(s): ___Text ___Email ___Cell

Employer _______________________________________ Full Time/Part Time Phone __________________

Language Spoken ___________ Understood _____________ Read ___________ In school/training? ☐ Yes ☐ No

Check highest completed: ___Less than HS diploma ___HS diploma/GED ___ Some college
___Associate's Degree ___Bachelor's Degree ___ Master's Degree

Parent/Step-parent/Guardian's Work History *(if in the same home as the child)* ***Attach proof of all income***

Parent Name	List all Employers in 2021	Date Started	Dated Ended	Gross Pay *(before taxes)*	How often are you paid?

If at any time in the year 2021, a parent in the home had no income, complete this box.

Parent Name	Dates (month/day/year) to (month/day/year)	Explain Lack Of Income (unemployed, did not work, med leave, etc.)
	to	
	to	
	to	

If at any time in the year 2021, a parent in the home was self-employed or there is no record of income, complete this box.

Parent Name	Gross Amount	Dates (month/day/year) to (month/day/year)	Source of income/Reason no record of income
		to	
		to	
		to	

Other Family Income

Complete *yes* or *no* if anyone in the home received any of the income listed in the year 2021.

___**Yes** ___**No** **Child Support:** Who received ____

What County? ____

When did it start? ________________________ End?_________________________

___**Yes** ___**No** **Unemployment:** Who received ____

When did it start? ________________________ End?_________________________

___**Yes** ___**No** **SSI:** (Supplemental Social Security): Who received? ___________________________

When did it start? ________________________ End?_____________________

___**Yes** ___**No** **Other Social Security: (SSDI, Survivor's Benefits, SS Retirement, etc.)**

Who received? ____

When did it start? ________________________ End?__________________________

___**Yes** ___**No** **TANF/OWF (Cash Assistance):** Who received __________________________

What County? ________________ When did it start? _________ End? ______________

___**Yes** ___**No** **Food Stamps/SNAP**

___**Yes** ___**No** **WIC**

___**Yes** ___**No** **Student Grants:** (Grants are money you do not have to pay back)

Amount you got in cash to you:$ ________ Which Semesters and year: ______________

___**Yes** ___**No** **Student Loans:** (Student Loans are money you have to pay back)

Amount you got in cash to you: $________ Which Semesters and year: _______________

___**Yes** ___**No** **Any other income:** Explain: ____

<u>If you have had very little or no income</u>, please explain how you have obtained food and shelter for the past year: (lived with parents, just divorced, etc.)____

____

Proof of this income is required. Please attach. If proof of income is not available, please talk to us.

Housing Situation

(Check all that apply):

Are you _____**Living in your own home**

If so, do you: ___Own/Buying ____Rent ___Metro or Subsidized Housing

_____ **Living in the home of family or friends (Check all that apply):**

If so, check why:
_____ due to eviction or foreclosure of your old home
_____ due to lack of money to get/keep own home
_____ due to recent marital or family break-up
_____ to care for family member who needs help
_____ because we choose to, or it is our culture
_____ other (explain below)

_____ **Overcrowded/Substandard Housing**
_____ **Child is in care of friends/relatives temporarily**
_____ **Temporary Living Situation**
_____ **Shelter**
_____ **Homeless**
_____ **Other** (explain below)

Please Explain Your Living Situation:
____
____

Family Circumstances

The following information will be used to help prioritize applications. This information is not required, but could help your child get into the Head Start Program. **Please check all that apply.**

Family Matter	Does this apply	If so, when
Absent Parent (due to work, military, illness, etc.)		
History of child abuse or neglect		
Current open case or investigation with Children Services		
Parent in jail/prison		
Legal issues		
Bankruptcy/Repossession		
Developmental Disability (anyone in the home)		
Substance or Alcohol Misuse (current or past)		
Domestic violence		

Family Matter	Does this apply	If so, when
Serious family concerns		
Counseling		
Mental health concerns (depression, bipolar, schizophrenia, etc.)		
Serious illness in family		
Death in the family (past year)		
Deceased parent		
Parent is a veteran		
Parent/Guardian has a driver's license	Yes	No
Parent/Guardian has reliable transportation	Yes	No
Other:		

Health/Disability Information

Providing this information is not required. Having this information now will help us to provide for the safety and well-being of your child, and determine the best way to provide quality services your child may need, without delaying your child's enrollment.

Do you know or suspect that your child has a disability? ☐ No ☐ Yes If yes, what is the disability? ___________________________

Is your child on an IEP? (Individual Education Plan through your local school) ☐ No ☐ Yes (If yes, we need a copy)

Does your child have any mental health issues? ☐ No ☐ Yes Diagnosis: ____
If so, what medications for it?____

Is your child toilet trained? ☐ No ☐ Yes

Does your child have a doctor? ☐ No ☐ Yes Name: ____

Does your child have a dentist? ☐ No ☐ Yes Name: ____

Does your child have medical coverage? (✓ all that apply)

___ Medicaid HMO/Healthy Start ___ Private Medical Insurance ___ Private Dental Insurance ____None

Allergies, Special Health or Medical Conditions

Fill in this section accurately and completely. Please note that if your child has a current health or medical condition requiring child care staff to perform child care specific care, such as: to monitor the condition, provide treatment, care or to give medication, the JFS 01236 "Child Medical/Physical Care Plan" or equivalent form and/or JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center.

Does your child have any food, medication, or environmental allergies? (check all that apply)
☐ No
☐ Yes – check all that apply ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Was food allergy diagnosed by a health professional? ☐ No ☐ Yes Child's age when first diagnosed with allergies/anaphylaxis _______

If the child is allergic to milk, check all they cannot eat: ☐ Fluid Milk ☐ Yogurt ☐ Sour Cream ☐ Cheese ☐ Cream Cheese

☐ Other____

Does your child's allergy/allergies require child care staff to monitor child for symptoms, take action if a reaction occurs, or give emergency medication to your child? (check one)
☐ No
☐ Yes – JFS 01236 "Child Medical/Physical Care Plan" must be completed.

Does your child have a development delay, special health or medical condition? (check one)
☐ No
☐ Yes - please explain:

Will the developmental delay, special health or medical condition require child care staff to perform a procedure, perform child care specific care, such as: to monitor your child for symptoms or administer medication during child care hours? (check one)
☐ No
☐ Yes - JFS 01236 "Child Medical/Physical Care Plan" must be completed.

Is your child currently using any medication or medical food (such as electrolyte solution)? (check one)
☐ No
☐ Yes – Please explain:

If yes, will this medication or medical food need to be administered at the child care center?
☐ No
☐ Yes – JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan" must be completed.

Will your child have any dietary restrictions, including those for medical, religious, or cultural reasons? (check one)
☐ No
☐ Yes – Please explain:

Will this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?
☐ No
☐ Yes

Record of Immunizations: A copy of the shot record must be attached

Share any other information you feel we may need to know about your child:

____

____

Signatures
&
Release of Information

____
Child's Name

____
Date of Birth

I give permission for HHWP CAC Head Start to exchange information with any school district, regarding IEP services if my child has a disability/suspected disability.

I give permission for HHWP CAC Head Start to exchange information with medical/dental providers/hospitals, as needed to follow up on any information provided on the Head Start physical and/or dental, or other Head Start forms regarding medical screenings, vision/hearing, iron/lead levels, allergies, and any special dietary concerns. This information could be used to provide for the safety and well being of my child, and to determine the best way to provide quality services, and to meet funder requirements.

I give the HHWP CAC Head Start permission to verify any information contained in, or needed to complete this Head Start application.

Medical providers/all hospitals, employers, DJFS, Social Security, CSEA, other agencies, and other entities may release information to HHWP CAC Head Start for the purpose of verifying family income, immunization records, health information, date of birth, and custody, for the purpose of enrolling my child in the Head Start Program.

All information will be kept confidential and HIPAA rules will be followed.

I attest that all information in this application is true and all sources of income received in 2021 are listed on the application. By signing below I am affirming I am the child's legal parent or guardian.

Parent Signature____________________________________ Date ____________

Printed Name ____

Parent Signature____________________________________ Date ____________

Printed Name ____

This release expires two years from the date of this signature unless revoked in writing.

Revised 1/2022 AR