Washita Valley
Community Action Council

HEAD START/EARLY HEAD START ENROLLMENT APPLICATION
2024-2025

Center to be enrolled: _____

Child's Name: _____Date of Birth:_____

Application Date:	**Program:** Circle One ☐ **Head Start** (3-5) ☐ **Early Head Start** (Birth-3)
1st Year ☐ **2nd Year** ☐ **3rd Year** ☐	☐ **Full Day** ☐ **Part Day**
Attended Early Head Start?	**Attended another Head Start Program?**

The following documents are needed for completion of an enrollment application.

□ Received	**Proof of Date of Birth**	**Copy of birth certificate, hospital record or other official document with date of birth (requirement)**
□ Received	**Income for 12-month period:** ****One of the items listed here is needed to have a completed application**	• **1040 Federal Income Tax Form** • **W-2 from all jobs worked** • **Check Stubs for the last 12 months** • **SSDI/ SS Document (If applies)** • **TANF or SNAP Letter (If applies)** • **Employer Statement on Letterhead**
□ Received	**Immunization Record/ Exemption**	**Refer to appendix ll, immunizations, in Requirements for Child Care Programs for immunization and exemption procedures.**
□ Received	**Completed Consent Page**	**Must contain parent/guardian signature (requirement)**
□ Received	**Insurance Card**	**Attach copy if available (not a requirement)**
□ Received	**Social Security Card**	**Attach copy if available (not a requirement)**
□ Received	**Parent and Staff Signatures**	**Requirement for completion.**

Immunizations

An immunization record or an exemption must be obtained prior to the first day of attendance and is to be kept updated when the child receives additional vaccines. Parent/ Guardian must provide a copy or give permission for the program to obtain the immunization record. Refer to appendix ll, immunizations, in Requirements for Child Care Programs for immunization and exemption procedure

- **The program policies have been provided to me upon enrollment and when revisions are made.**
- **Selecting Child Care Programs, DHS publication "A Parent Guide" 87-91, Licensing Requirements for Child Care Programs, DHS publication 14-05, and the program compliance file are all made accessible to parents in a prominent location.**

Child Care Program Use

Entry Date: _____ Withdrawal Date: _____ Transfer Date: _____

Child Information (Child's Legal Name)

First Name:	Middle Name:		Last Name:
Date of Birth: _____/_____/_____	Male ☐ Female ☐	Contact Number: (Include area code) Name of Contact:	Primary Language: Secondary Language: ☐ Little ☐ Moderate ☐ Proficient
Child's Social Security # _____- _____-_____			
Home/ Street Address:	City:	Zip: County	Parent/Guardians whom the child lives with:
Mailing Address:	City	Zip: County	*If Shared Custody- Is there custody documentation:*
Child's Ethnicity: Hispanic or Latino Origin ☐ Non-Hispanic/Non-Latino Origin ☐	Child's Race: ☐ Black/ African American ☐ White ☐ Biracial/Multiracial ☐ American Indian/ Alaskan Native ☐ Pacific Islander/ Native Hawaiian ☐ Other :		

Special Needs Information

Do you have any concerns about this child's behavior or development? ☐ Yes ☐ No

☐ Behavior/Emotional Problems ☐ Developmental Delays ☐ Seizures/Convulsions ☐ Hyperactivity
☐ Chronic Health Problems (such as Asthma, Diabetes, Arthritis) ☐ Rashes ☐ No significant health concerns

Does your child have specific needs involving routine care, behavior modification, communication, eating, or sleeping activities? ☐ Yes ☐ No When yes, Describe: _____

Has your child been diagnosed with a specific disability or need? ☐ Yes ☐ No When yes, list: _____

Is this child on an IEP or IFSP? ☐ Yes ☐ No **Has this child been referred?** ☐ Yes ☐ No

Will your child receive any specialized services from professionals from outside of this program's personnel?
☐ Yes ☐ No

Medical Information

Please indicate which types of insurance this child currently receives (Check all that apply)

☐ Soonercare ☐Direct Purchase ☐Employment Based ☐Tri-care ☐Indian Health Services ☐ None

Child's Dr:	Phone:		Date of Last Physical:
Clinic Address:	City:	State:	Zip:
Child's Dentist	Phone:		Date of Last Checkup:
Dentist Clinic Address:	City:	State:	Zip:

Does your child have any known allergies? ☐ Yes ☐ No When yes, list: _____

Does the known allergy require any special precautions, actions, or medications? ☐ Yes ☐ No

When yes, Describe: _____

☐ **I understand that a signed parent/guardian permission is obtained prior to administration of medication**

Adult, Guardian, or Parent the child lives with:

First Name:		Last Name:		Relationship to Applicant
Date of Birth: _____/_____/_____ **Social Security #**	**Male** ☐ **Female** ☐	**Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Co-Habitating	**Home/Cell phone number**	**Primary Language:** **Secondary Language:** ☐ Little ☐ Moderate ☐ Proficient
Ethnicity: Hispanic or Latino Origin ☐ Non-Hispanic/Non-Latino Origin ☐		**Race:** ☐ Black/ African American ☐ White ☐ Biracial/Multiracial ☐ American Indian/ Alaska Native ☐ Pacific Islander/ Native Hawaiian ☐ Other :_____ **Email**:_____		
Pregnant: ☐ No ☐ Yes **Due Date:**_____		**Housing:** ☐ Rent ☐ Own ☐ Homeless **(Must attach questionnaire)**	**Education Level:** ☐ Non-Graduate Highest Grade:_____ ☐ Diploma ☐ GED ☐ Some college ☐ Associates ☐ Bachelor ☐ Masters ☐ Vocational	
Employment: ☐ **Unemployed** **Date Became UNEMPLOYED:**_____ ☐ **Part-time (<35 hrs)** ☐ **Full time (35+)** **IF EMPLOYED # Months**_____ ☐ **Active Military** ☐ **Retired/ Disabled** ☐ **Seasonally Employed** **Place Of Employment:** **Phone #**			**Are you a Veteran?** ☐ Yes ☐ No **Are you Active Military?** ☐ Yes ☐ No **Are you Disabled?** ☐ Yes ☐ No	
Currently Attending School? **Online OR In-Person?** **Where?**		**Health Insurance?** ☐ Yes ☐ No ☐ Direct Purchase ☐ Employment Based ☐ Medicaid ☐ Medicare ☐ Military ☐ State Insurance for Adults		

Adult, Guardian, or Parent the child lives with:

First Name:		Last Name:		Relationship to Applicant
Date of Birth: _____/_____/_____ **Social Security #**	**Male** ☐ **Female** ☐	**Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Co-Habitating	**Home/Cell phone number**	**Primary Language:** **Secondary Language:** ☐ Little ☐ Moderate ☐ Proficient
Ethnicity: Hispanic or Latino Origin ☐ Non-Hispanic/Non-Latino Origin ☐		**Race:** ☐ Black/ African American ☐ White ☐ Biracial/Multiracial ☐ American Indian/ Alaska Native ☐ Pacific Islander/ Native Hawaiian ☐ Other :_____ **Email**:_____		
Pregnant: ☐ No ☐ Yes **Due Date:**_____		**Housing:** ☐ Rent ☐ Own ☐ Homeless **(Must attach questionnaire)**	**Education Level:** ☐ Non-Graduate Highest Grade:_____ ☐ Diploma ☐ GED ☐ Some college ☐ Associates ☐ Bachelor ☐ Masters ☐ Vocational	
Employment: ☐ **Unemployed** **Date Became UNEMPLOYED:**_____ ☐ **Part-time (<35 hrs)** ☐ **Full time (35+)** **IF EMPLOYED # Months**_____ ☐ **Active Military** ☐ **Retired/ Disabled** ☐ **Seasonally Employed** **Place Of Employment:** **Phone #**			**Are you a Veteran?** ☐ Yes ☐ No **Are you Active Military?** ☐ Yes ☐ No **Are you Disabled?** ☐ Yes ☐ No	
Currently Attending School? **Online OR In-Person?** **Where?**		**Health Insurance?** ☐ Yes ☐ No ☐ Direct Purchase ☐ Employment Based ☐ Medicaid ☐ Medicare ☐ Military ☐ State Insurance for Adults		

House Hold Information:

(Information regarding OTHER people living in household) Use the key below for codes

Name	Date of Birth	Social Security Number	Gender	Relation To applicant	Ethnicity	Race	Education	Health Insurance	Current HS/EHS Child	Supported by income of Parent/Guardian
1.										
2.										
3.										
4.										
5.										

Relation to Applicant	Ethnicity	Race	Education List Highest grade completed	Health Insurance
A. Brother B. Sister C. Grandparent D. Other Related	A. Hispanic or Latino B. Non-Hispanic or Non-Latino	A. American Indian or Alaskan Native B. Asian C. Black/African American D. White E. Hawaiian/Pacific Islander F. Multi-Race G. Other	A. 0-8th Grade B. 9-12th Grade C. High School Grad D. GED E. 12 + Some Secondary School F. 2 Year College Graduate G. 4-Year College Graduate H. Masters Degree	A. Direct Purchase B. Employment Based C. Medicare D. Military E. Sooner Care F. State Ins. For Adults G. Indian Health Serv. H. None

Does your family receive? ☐ TANF ☐ SNAP ☐ SSI ☐WIC ☐ Child Care Assistance ☐Affordable Care Act Subsidy ☐Housing Choice Voucher ☐RHUD-VASH ☐Public Housing ☐ Permanent Supportive Housing ☐ LIHEAP ☐ None

Parental Status: ☐ One parent ☐ Two parent ☐ Foster Child ☐ Non-parent ☐ Other: _____

Emergency Contact Information

List individuals to notify, in case of emergency, ***when a parent or guardian cannot be reached***. List in order of preference.

Name:	Telephone Number (Include Area Code)	Relationship to the child	Authorize to Contact	Authorize to Release
1.				
2.				
3.				

WASHITA VALLEY CAC FAMILY RESIDENCY QUESTIONNAIRE

Note: *As of December 12, 2007 with the passage of the Head Start Reauthorization Act of 2007, any child whose current* housing situation entitles them to services under section 725(2) of the McKinney-Vento Act (42 U.S.C. 11435(2) is considered automatically eligible for Head Start services. Eligibility may be determined by completing this questionnaire.

Name of Parent Filling out Questionnaire: _____

Name of Child: _____

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine whether the child may be automatically eligible for Head Start services.

1. Is your current address a temporary living arrangement? CIRCLE ONE **YES** ☐ or **NO** ☐

2. Is this temporary living arrangement due to loss of housing or economic hardship? CIRCLE ONE **YES** ☐ or **NO** ☐

If you answered NO to both questions above, this child is not automatically eligible for Head Start under the McKinney-Vento Act. Sign and Date and proceed to the next page.

Parent/Guardian Signature: _____ Date: _____

If you answered YES to either of the questions above:

Where is the family presently living? Address: _____ (Check a box below)

- ☐ In a motel
- ☐ In a shelter
- ☐ Sharing the housing of others
- ☐ Moving from place to place
- ☐ In a place not designed for ordinary sleeping accommodations such as a car, park, or campsite.

I give the Head Start Staff authorization to contact the person identified below to verify my homeless status.

Name of Reference:_____ Relationship to Parent: _____

Reference Contact Number: _____

I certify that the information I have given is correct to the best of my knowledge. I understand that if the program determines that my child does not automatically qualify for Head Start services under the McKinney-Vento Act, acceptance into the program will be decided based on the program's current child eligibility criteria.

Parent/Guardian Signature: _____ Date: _____

****

Based on the information above and through interview with the family, I attest that to the best of my knowledge that this child is ☐ **Eligible** ☐ **NOT Eligible** for enrollment in the Head Start program based on the McKinney-Vento Act.

Staff Signature: _____ Date: _____

Income/Employment Information

If this is a Homeless Family, a Foster Family, OR if anyone in the household receives SSI, TANF, or SNAP then skip this income/employment portion and go to the bottom to sign and date.

Head Start/Early Head Start is an income eligible program. We must verify the family's household income
Verifying eligibility -- To verify eligibility based on income, program staff must use tax forms, pay stubs, or other proof of income to determine the family income for the relevant time period (A, B, or C)

(A) the 12 months preceding the month in which the application is submitted

(B) during the calendar year preceding the calendar year in which the application is submitted

(C) If the family can demonstrate a significant change in income for the relevant time period, program staff may consider current income circumstances.

Parent/Guardian # 1
In the last 12 months did you work?
☐ YES: Describe Months Worked: _____
_____

☐ NO: How were bills and necessities paid for: _____
_____

Parent/Guardian # 2
In the last 12 months did you work?
☐ YES: Describe Months Worked: _____
_____

☐ NO: How were bills and necessities paid for: _____
_____

If employed you MUST attach employment documents for each adult/guardian who is employed (ALL W-2s, Tax form(s), OR paycheck stubs for last 12 months)

****If no employment history or does not receive SNAP then a *Self-Declaration and 3rd Party Verification Forms MUST be filled out***

****How did you hear about our program?****

☐ Flyer ☐ Staff ☐ Newspaper ☐ Family/Friend ☐ DHS ☐ Social Media ☐Other: _____

I understand that this is an application for services offered and does not constitute enrollment into any program. I certify that the information given on this application is true and accurate and all income has been reported. I understand that this information is being given for the receipt of federal and/or state funds; that officials may verify the information on this application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable federal and/or state laws.

Parent/Guardian Signature*: (required)* _____ **Date:** _____

Interviewer's Signature: *(required)* _____ **Date:** _____

WVCAC Head Start & Early Head Start

Parental/ Guardian Consent

Child's Name_____ **Date of Birth**_____

I hereby give permission for Washita Valley CAC Head Start/ Early Head Start to:

- The Brigance EHS/Head Start Screen III is used to assess children from birth through five years of age. The screen reflects a view of the child's growth and learning. The purpose of this screening is to gather a broad sampling of a child's skills and behaviors. **I agree to Brigance Screen** □ Yes □ No _____ ***(parent initials)***

- A screening is conducted by a speech pathologist at the public school or with a private agency that is used to help staff and parents recognize when there may be a need for further evaluations and/or services. **I agree to Speech Screen** □ Yes □ No _____ ***(parent initials)***

- These screenings are conducted by trained Head Staff using an audiometer for hearing Good-Lite vision screen for vision**. I agree to Vision and Hearing Screen** □ Yes □ No _____ ***(parent initials)***

- Each child is measured 2 times a year by teaching staff. The results are graphed to determine the child's height and weight percentile. **I agree to Height and Weight** □ Yes □ No _____ ***(parent initials)***

- Teaching Strategies Gold is an on-going assessment that enables staff to assess and observe children to set individualized goals for each child. **I agree to Teaching Strategies Gold** □ Yes □ No _____ ***(parent initials)***

- The program provides children with dental education, toothbrushes, and fluoride toothpaste. **I agree to my child using fluoride toothpaste** □ Yes □ No _____ ***(parent initials)***

- WVCAC has access to print/ or view a copy of the immunization record from OK state website (OSIIS). **I agree to allow my child's immunization record to be viewed/printed*)*** □ Yes □ No _____ ***(parent initials)***

- Use child's photo in classroom, newspaper, newsletter, or video. **I agree to my child's photo being used** □ Yes □ No _____ ***(parent initials)***

- **Parents will always be the first point of contact in regard to minor medical emergencies. If a major medical emergency occurs WVCAC will contact local Emergency personnel for transportation and then will contact the parent/guardian listed on the application.**

_____ _____

Parent/Guardian Signature **Date**

OSIIS - Authorization to Use or Share Protected Health Information to School or Day Care

Student Name:_____ Demographic/Client ID #:_____
(For School/Day Care receiving PHI to fill out)

Date of Birth:_____

I hereby authorize the Oklahoma Immunization Service to release my Immunization records and information located within the Oklahoma State Immunization Information System ("OSIIS") to: Washita Valley CAC HS/EHS.
(*Name of Person/Organization receiving PHI*)

The information may be disclosed for the following purpose(s):

☑ to ensure the student meets Oklahoma eligibility requirements for schools/day cares as outlined in Title 70 O.S. § 1210.191 and Oklahoma Administrative Code ("OAC") 310:535-1-2 and OAC 310: 535-1-3

☐ Other: _____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information and revoke this authorization at any time in writing.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.
- I understand I may change this authorization at any time in writing. However, I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy Regulations.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be **one year** from the date of my signature or upon the occurrence of the following event [*e.g.*, child no longer enrolled in school/day care center] _____.

_____.

_____ _____
Signature of Student or Legal Representative Date

_____
Description of Legal Representative's Authority