

Washita Valley Community Action Council
Head Start/ Early Head Start Enrollment Application
2022-2023

Center to be enrolled: _____ K8 # _____

Child's Name: _____ Date of Birth: _____

Application Date:	Program: <input type="radio"/> Head Start (3-5) <input type="radio"/> Early Head Start (Birth-3)
<input type="radio"/> 1 st Year <input type="radio"/> 2 nd Year <input type="radio"/> 3 rd Year	<input type="radio"/> Full Day <input type="radio"/> Part Day
Attended Early Head Start? <input type="checkbox"/> Yes	Attended another Head Start Program? <input type="checkbox"/> Yes

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

<input type="checkbox"/> Received	Proof of Date of Birth	Copy of birth certificate, hospital record or other official document with date of birth (requirement)
<input type="checkbox"/> Received	Income for 12-month period: <i>**One of the items listed here is needed to have a completed application</i>	<ul style="list-style-type: none"> 1040 Federal Income Tax Form W-2 from all jobs worked Check stubs for the last 12 months SSI/SSDI/SS Document (If applies) TANF or SNAP Letter (If applies) Employer Statement on letterhead
<input type="checkbox"/> Received	Immunization Record/ Exemption	Refer to appendix II, immunizations, in Requirements for Child Care Programs for immunization and exemption procedures.
<input type="checkbox"/> Received	Completed Consent Page	Must contain parent/guardian signature (requirement)
<input type="checkbox"/> Received	Insurance Card	Attach copy if available (not a requirement)
<input type="checkbox"/> Received	Social Security Card	Attach copy if available (not a requirement)
<input type="checkbox"/> 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 II, 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.

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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 <input type="radio"/> Female <input type="radio"/>	Contact Number (Include area code)	Primary Language:		
Child's Social Security #		Name of Contact	Secondary Language:		
			<input type="radio"/> Little <input type="radio"/> Moderate <input type="radio"/> Proficient		
Home/ Street Address:	City:	Zip:	Parent/Guardians whom the child lives with:		
		County			
Mailing Address:	City	Zip:	<i>If Shared Custody- Is there custody documentation:</i>		
		County			
Child's Ethnicity: Hispanic or Latino Origin <input type="radio"/> Non-Hispanic/Non-Latino Origin <input type="radio"/>	Child's Race: <input type="checkbox"/> Black/ African American <input type="checkbox"/> White <input type="checkbox"/> Biracial/Multiracial <input type="checkbox"/> American Indian/ Alaskan Native <input type="checkbox"/> Pacific Islander/ Native Hawaiian <input type="checkbox"/> 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 When yes, I understand that a signed and dated parent permission is required.

I give permission for program personnel to consult with specialized personnel regarding the needs of my child?

Yes No Parent Comments: _____

Medical Information

Please indicate which types of insurance this child currently receives (Check all that apply)					
<input type="checkbox"/> Soonercare	<input type="checkbox"/> Direct Purchase	<input type="checkbox"/> Employment Based	<input type="checkbox"/> Tri-care	<input type="checkbox"/> Indian Health Services	<input type="checkbox"/> 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

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: _____
(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

Adult, Guardian, or Parent the child lives with:

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

Adult, Guardian, or Parent the child lives with:

First Name:		Last Name:		Relationship to Applicant
Date of Birth:	Male <input type="radio"/> Female <input type="radio"/>	Marital Status:	Home/Cell phone number	Primary Language:
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Ethnicity: Hispanic or Latino Origin <input type="radio"/> Non-Hispanic/Non-Latino Origin <input type="radio"/>		Race: <input type="checkbox"/> Black/ African American <input type="checkbox"/> White <input type="checkbox"/> Biracial/Multiracial <input type="checkbox"/> American Indian/ Alaskan Native <input type="checkbox"/> Pacific Islander/ Native Hawaiian <input type="checkbox"/> Other : _____ Email: _____		
Pregnant: <input type="radio"/> No <input type="radio"/> Yes Due Date: _____	Housing: <input type="radio"/> Rent <input type="radio"/> Own <input type="radio"/> Homeless (Must attach questionnaire)		Education Level: <input type="radio"/> Non-Graduate Highest Grade: _____ <input type="radio"/> Diploma <input type="radio"/> GED <input type="radio"/> Some college <input type="radio"/> Associates <input type="radio"/> Bachelor <input type="radio"/> Masters <input type="radio"/> Vocational	
Employment: <input type="checkbox"/> Unemployed Date Became UNEMPLOTED: _____ <input type="checkbox"/> Part-time (<35 hrs) <input type="checkbox"/> Full time (35+) IF EMPLOYED # Months _____ <input type="checkbox"/> Active Military <input type="checkbox"/> Retired/ Disabled <input type="checkbox"/> Seasonally Employed			Are you a Veteran? <input type="radio"/> Yes <input type="radio"/> No Are you Active Military? <input type="radio"/> Yes <input type="radio"/> No Are you Disabled? <input type="radio"/> Yes <input type="radio"/> No	
Place Of Employment:		Phone #		
Currently Attending School? <input checked="" type="radio"/> Yes <input type="radio"/> No Online or On Campus ? Where?		Health Insurance? <input checked="" type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/> Direct Purchase <input type="checkbox"/> Employment Based <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Military <input type="checkbox"/> State Insurance for Adults		

House Hold Information:

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

Name	Date of Birth MM/DD/YYYY	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. 0-8 th Grade B. 9-12 th 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	Relationship to the child	Authorize to Contact	Authorize to Release
1.	-		<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>

WVCAC Family Residency Questionnaire

McKinney-Vento Act Residency and Educational Rights Information

(Questionnaire must be completed for each student)

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 (U.S.C. 11435(2)) is considered automatically eligible for Head Start/Early Head Start services. Eligibility may be determined by completing this questionnaire.

Name of Parent Completing 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/Early Head Start Services.

1. Is your current address a temporary living arrangement? Yes No
2. Is this temporary living arrangement due to loss of housing or economic hardship? Yes No

If you answer "No" to both of the questions above, child is not automatically eligible for Head Start/Early Head Start under the McKinney-Vento Act.

******Staff and parent signatures are still required.******

Where is the family presently living? (Check one box.):

- Living in a shelter, including transitional housing shelters; awaiting foster care, etc.*
- Living on the streets, abandoned buildings, in cars, trailers, campgrounds, public places, and housing not fit for habitation.*
- Living in hotels/motels for lack of other suitable housing.*
- Moving from place to place.*
- Doubled-up; **Temporarily** living with family or friends due to lack of adequate housing or financial conditions.*

Address: _____ **Zip:** _____ **Phone:** _____

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/Early Head Start services under the McKinney-Vento Act, acceptance into the program will be decided based on the program's current child eligibility criteria.

Signature of Parent/Guardian/Unaccompanied Youth

Date

Office Use Only:

Eligible under McKinney-Vento Act

Not Eligible

Staff Signature

Date

Income/Employment Information

If this is a Homeless Family, a Foster Family, OR if anyone in the household receives SSI or TANF then skip this income/employment portion

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 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, tooth brushes, and fluoride toothpaste. **I agree to my child using fluoride tooth paste** 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 regards 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