DELTA HEAD START/EARLY HEAD START
308 SW 2nd
Lindsay, OK 73052
405-756-1100
Fax 405-756-1104

Delta Community Action
Karen Nichols, Executive Director

Sheresa Patrick
Head Start/Early Head Start Director

Delta Head Start/Early Head Start Eligibility Application

Delta Head Start provides a free pre-school program and comprehensive services to children 3 and 4 years of age and their families who are eligible.

Delta Early Head Start provides comprehensive services to pregnant women, infants, and toddlers and their families who are eligible.

Please complete the attached application completely and accurately. All information will be kept strictly confidential. It will be used to determine whether your family is eligible for Head Start/Early Head Start services and to prioritize your application.

If you have any questions about this application, or if you need any help completing it, please call us at Lindsay, 405-756-1100, Duncan, 580- 255-5571, or Purcell, 405-527-5551. We will be glad to assist you!

INCOMPLETE APPLICATIONS CANNOT BE PROCESSED

When we receive your application, we will review it and let you know if your family qualifies for Delta Head Start/Early Head Start or if we need more information. **Please let a Delta Head Start/Early Head Start Staff know of any changes in your phone number, address and/or your interest in our program.**

This form will become a permanent part of your child's Head Start/Early Head Start enrollment if accepted in the program.

Please attach the following documentation to this application:

1. **State certified birth certificate**
2. **Updated immunization record**
3. **Family Income Verification**
4. **Social Security Card (if available)**

Please mail or drop off your completed applications to:

Delta Head Start/Early Head Start
308 SW 2nd
Lindsay, OK 73052

Child/Participant's Information:

Child/Participant's Name_____ _____ _____ Gender: _____
(First) (MI) (Last)

Physical Address_____City_____Zip_____ Telephone_____

Mailing Address_____Email Address_____

County_____School District_____

Date of Birth_____ Preferred Language: _____ Race/Ethnicity_____

Does child have current immunizations? ☐Yes ☐No (Please provide documentation of immunization record or documentation of exemption).

IF YOU ARE PREGNANT: Due Date (mm/yy): _____ **Are you receiving prenatal service**? ☐Yes ☐No

FAMILY INFORMATION: All blanks must be completed unless otherwise stated.

	MOTHER/LEGAL GUARDIAN	**FATHER/LEGAL GUARDIAN**
Name		
Parent lives in the same house as child?	☐ Yes ☐ No	☐ Yes ☐ No
If parent does not live with child, please provide address and phone number.	Address_____ City_____Zip_____ Telephone_____	Address_____ City_____Zip_____ Telephone_____
Date of birth (Must be completed)		
What ethnicity do you consider yourself to be?	☐Hispanic or Latino ☐Non-Hispanic or non-Latino	☐Hispanic or Latino ☐Non-Hispanic or non-Latino
What race do you consider yourself to be? (check one only)	☐White ☐American Indian ☐Asian ☐Black /African American ☐Hispanic or Latino ☐Native Hawaiian or Pacific Islander ☐Biracial/Multiracial or Other (Specify)_____	☐White ☐American Indian ☐Asian ☐Black /African American ☐Hispanic or Latino ☐Native Hawaiian or Pacific Islander ☐Biracial/Multiracial or Other (Specify)_____
Primary Language Spoken:		
Secondary Language(s) Spoken:		
English Speaking Ability:	☐Not at All ☐Not Well ☐Well ☐Very Well	☐Not at All ☐Not Well ☐Well ☐Very Well
Primary Occupational Status *(Mark only one):*	☐Full-time (30+ hours weekly) ☐Unemployed ☐Part-time (<29 hours weekly) ☐Training program with salary ☐Homemaker ☐Unable to work due to disability ☐Self-Employed or other (specify)_____	☐Full-time (30+ hours weekly) ☐Unemployed ☐Part-time (<29 hours weekly) ☐Training program with salary ☐Homemaker ☐Unable to work due to disability ☐Self-Employed or other (specify)_____
Hours worked?	From: _____ Sun Mon Tue Wed Thu Fri Sat To:_____ ☐ ☐ ☐ ☐ ☐ ☐ ☐	From: _____ Sun Mon Tue Wed Thu Fri Sat To:_____ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Enrolled in school?	☐Yes Sun Mon Tue Wed Thu Fri Sat Where? ☐No ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐Yes Sun Mon Tue Wed Thu Fri Sat Where? ☐No ☐ ☐ ☐ ☐ ☐ ☐ ☐
Highest Level of Education Completed:		

Household Income: Include income of all household members contributing support for above child.
You must provide proof of income. Income proof could be, but not limited to the following:
pay stub, employer statement, TANF, child support, college grants/scholarships, SSI, alimony, and/or foster care subsidy.

Type of income submitted:
☐ Paystubs ☐ Family Support ☐ Individual Tax Form 1040
☐ W-2 Form ☐ SNAP (food stamps) ☐ Written statement from employer
☐ TANF ☐ SSI ☐ Child Suppot ☐ Other_____ (Please Specify

Family Size
To process your child's application, we must know how many people are living in your household and who are supported by the parents/guardians of the child applying for the program.

How many **adults** in household? _____ How many **children**? _____

Please list everyone living in the same home as the child, who is related to the child by blood, marriage or adoption AND who is supported by the child's parent/guardians. (brothers, sisters, uncles, aunts, grandparents, etc.)

NAME	SEX	DOB	RELATIONSHIP TO CHILD

Family Type: ☐ Single Parent (Mother Only) ☐ Foster Parents
☐ Single Parent (Father Only) ☐ Grandparent(s) or other relatives
☐ Two Parent ☐ Other Family Type:_____

Is the child's family currently homeless? (Includes families living temporarily in a shelter, hotel, or vehicle; or moving frequently between homes of relatives and friends) ☐ Yes ☐ No

If yes, how long has family been homeless?: _____

Types of Services or Financial Assistance Received: (Mark all that apply)
☐ WIC ☐ Tribal ☐ Social Security Income
☐ TANF ☐ Foster Care Subsidy ☐ Daycare Assistance
☐ SNAP ☐ Medical (Soonercare)

Will you provide transportation for your child to and from Head Start? _____. If not, how will child get to and from Head Start? _____.

CHILD HEALTH

Is your child up to date with Well Child Checks? ☐ Yes ☐ No If so when was your child's last visit?_____

Has your child had a Lead Screening from WIC or a Doctor? ☐ Yes ☐ No If yes, when? _____

Any concerns about child health and/or development? ☐ Yes ☐ No Specify concern: _____
(Please attach medical documents)

Has child been determined eligible for Local Education Agency (LEA) or Sooner Start to receive special education services and/or related services? ☐ No ☐ Yes (IEP) ☐ Yes(IFSP) *If yes, please provide documentation

Has Child been diagnosed with a medical or biological issue? (Such as Asthma, food allergies, epi-pen, use inhaler, allergies to insects, diabetes, seizures, any and all allergies, heart, heat, etc.) ☐ Yes ☐ No If yes, specify: _____

******If your child has any of the listed or any other medical issue, your child must have a Medical Plan in place before child may start school. NO EXCEPTIONS!**

Will your child need medication during school hours? ☐ Yes ☐ No specify: _____

******If yes, your child must have a Medication Administer Plan in place before child may start school. NO EXCEPTIONS!**

ALL MEDICAL/MEDICATION PLANS AVAILABLE UPON REQUEST.

****Delta Head Start and Daycare licensing requires Delta have medical plans in place to be able to safely provide care to your child.**

*****Having a medical issue will not have any bearing on your child's acceptance into Delta Head Start/Early Head Start. *****

TYPE OF PROGRAM OPTION INTERESTED IN: (Please check only one)

☐ **Head Start Program** - This program consists of center -based services for children 3 and 4 years of age.

☐ **Early Head Start - Full Day** | This option is for working or student families that need full day childcare. This program services children 6 weeks to age 3 and operates Monday-Friday. Families have home visits and parent/teacher conferences. Proof of full-time employment or school is required for this option

☐ **Early Head Start - Home Based** | This program consists of weekly home visits, socialization groups twice a month where child interacts with other children in a classroom environment and parent groups. Childcare and snacks are provided for all groups and socializations.

☐ **Prenatal Program** | This program consists of home visits during pregnancy to provide education and support. Once the baby turns 6 weeks old, he/she is automatically enrolled in one of the programs mentioned above. (providing eligibility is met)

Special Circumstances
If you would like, please describe any special challenges and/or circumstances facing your family.

Please review your child's application and ensure all empty fields are answered. Incomplete applications cannot be processed.

☐ By checking this box, I certify that the income and information stated in this application to be true and correct to the best of my knowledge.

Type your full legal name here as a signature_____ Date_____

AGENCY USE ONLY

Interviewed by_____

Center Applying For: _____ ☐Head Start ☐Early Head Start ☐Pregnancy Program

Documentations: Staff check off the documents received.

Income Verifications_____

Immunization Record _____

State Certified Birth Certificate_____

Documentation of Disability/Medical Condition (if applicable) _____

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

Student Name:_____ Demographic/Client ID #:1957
(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: Delta Head Start / Early Head Start.
(*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