LITTLE DIXIE EARLY HEAD START

BIRTH TO 36 MONTHS

Thank you for applying for ***Little Dixie Early Head Start*** . In order to process your child's application, copies of:

proof of income of all household members,
child's certified birth certificate or hospital birth record, and
a copy of a current immunization record

must be attached. If your child has been diagnosed with a disability, we must have a copy of any record, evaluations or IFSP to consider your child for a priority based on a diagnosed disability.

If your child is accepted into the Early Head Start program, we will also need copies of private insurance cards and proof of Public Assistance (ex: CDIB, food stamps, TANF, Medicaid, etc- we will make a copy for your child's folder). While we do not require these items at the time of this application, we do require them to be presented at enrollment. Providing these items now with this application will simplify things at enrollment time. In addition to these items, at least one parent/ guardian/family member will be required to be oriented to the Early Head Start program before our child is allowed to attend the program.

You can mail or fax your application and appropriate paperwork to:

Little Dixie Early Head Start
209 North 4th
Hugo, OK. 74743

Phone: 1-866-326-7581
Fax: 1-580-326-7584

Please make sure you include proper postage on the envelope.

Acceptance into Early Head Start is determined by priority based on a point system. You will be notified if your child is accepted or placed on a waiting list as soon as possible.

Thank you for applying for Early Head Start!

LITTLE DIXIE C.A.A. Early Head Start
209 NORTH 4TH STREET
HUGO, OK. 74743
(580) 326-7581
1-866-326-7581

EARLY HEAD START APPLICATION
BIRTH TO 36 MONTHS

Agency Use Only

Center: _____ Age: _____
Type: _____ Education: _____
Sus. Dis: _____ Ident. Dis: _____
Prev. Child Develop. Program: _____
Family: _____ Children: _____
Child Age: _____ Parent Age: _____
Income: _____
Referral: _____ **Total:** _____
Center Accepted: _____
Date Accepted: _____

Assurance of Confidentiality: The information on this form is being requested on a voluntary basis. The information you provide will help us deliver or direct services most appropriate for your family's needs. If you prefer not to provide some of the information, it will not affect the services we try to deliver. However, some information is required for eligibility determination. All information will be held in strict confidence.

Child's Name: _____
First Name MI Last Name

Nickname: _____ Date of Birth: _____/_____/_____

Social Security # of Applying Child: _____/_____/_____ Gender: _____Male _____Female

Living Address: _____ _____
Street Town/City/Zip Code

_____ _____
Home Telephone Number Work Telephone Number

_____
Message Number If Available

Mailing Address: _____ _____
Street Town/City/Zip Code

What race/ethnicity do you consider this child to be?

_____ White _____ Black _____ American Indian

_____ Asian - Please Specify: _____ _____ Other - Please Specify: _____

What language does this child speak at home? Primary Language:_____

If English is the second language, how well does this child speak English?

_____ Very Well _____ Well _____ Not Well _____ Not At All

Do you or anyone else have any concerns about this child's over all health and development?_____

Has this child been identified as having, or is suspected to have, any of the following:

	Suspected:	Identified:	Date:	Evaluated By:
Asthma				
Autism				
Severity:				
Emotional/Behavior Disorder				
Severity:				
Aggressive Behavior				
Health Impairment				
Type:				
Hearing Impairment				
Percent of Hearing loss:				
Mental Retardation				
Down Syndrome				
Severity:				
Orthopedic Impairment				
Speech/Language Impairment				
Traumatic Brain Injury				
Visual Impairment				
Severity:				
Cerebral Palsy				
Severity:				

Is this child being seen by Sooner Start or any other professional? _____ Yes _____ No

Have you, your spouse or any other of your children previously been enrolled in Head Start/ Early Head Start or other child development program? _____ Yes _____ No

If yes, specify which progam(s) this child has attended and date(s) of attendance.

_____ Early Head Start From ____/____/____To ____/____/____

_____ OPAT (Parents As Teachers) From ____/____/____To ____/____/____

_____ Children First From ____/____/____To ____/____/____

_____ Bright Beginnings From ____/____/____To ____/____/____

_____ Head Start From ____/____/____To ____/____/____

_____ Other From ____/____/____To ____/____/____

What Little Dixie Early Head Start county are you applying for? _____

Name of Primary Supporting Adult: _____
First M Last

Relationship to Child: _____

Date of Birth: _____/_____/_____

Social Security Number of Primary Supporting Adult: _____/_____/_____

What is the highest level of education you have completed? (mark only one)

_____ No school completed
_____ Less than or equal to 4th grade
_____ 5th-8th grade
_____ 9th grade
_____ 10th grade
_____ 11th grade
_____ 12th grade
_____ High school graduate (high school diploma or equivalent, e.g. GED)
_____ Some college - but no degree
_____ Associate degree
_____ Bachelor degree
_____ Master degree
_____ Doctorate degree

How many adults are there in your family? _____ Adults

How many children are there in your family? _____ Children

Are you or your spouse currently pregnant?

_____ Yes _____ No _____ Not applicable

List **all household members** and their relationship to the applying child. You may attach an additional sheet of paper if necessary. ***Please only list the people living in the home.***

Father	Date of Birth	Social Security #
Mother	Date of Birth	Social Security #
Family Member	Relationship to Applying Child	Date of Birth
Family Member	Relationship to Applying Child	Date of Birth
Family Member	Relationship to Applying Child	Date of Birth

Which of the following descriptions best fits the child's family: (check only one)

_____ Foster Family
_____ Other Relatives
_____ Single Parent Family (Father Figure Only)
_____ Single Parent Family (Father Figure Only) Living With Partner
_____ Single Parent Family (Mother Figure Only)
_____ Single Parent Family (Mother Figure Only) Living With Partner
_____ Two Parent Family
_____ Other: Specify _____

What is your family's yearly gross income? $ _____

Based on the income verification you attached, how often do you get paid?

_____ (Example: Weekly, Monthly, etc.)

Do you currently live with family or friends? _____ Yes _____ No

Does your family receive any of the following types of services or financial assistance?

_____ Medical Financial Assistance (Ex.: SoonerCare/Medicaid/Medicare)
If yes, SoonerStart/Medicaid number including person code: _____

_____ Food Stamps
_____ Public Assistance/Welfare (Ex.: TANF)
_____ WIC
_____ Supplemental Security Income (SSI)
_____ Foster Care/Adoption Subsidy
_____ Public Housing Assistance
_____ Energy Program Assistance
_____ EPSDT
_____ Child Support/Alimony
_____ Title XX Day Care Assistance
_____ Living Assistance Provided By Family or Friends
_____ Other: Specify _____

If you are receiving public assistance, indicate date you began receiving services: _____/_____/_____

Has your family applied to receive social security income (SSI)? _____ Yes _____ No

I certify the information provided in support of this application is accurate and truthful to the best of my knowledge.

Signature: _____ Date: _____/_____/_____
Parent/Guardian

AGENCY USE ONLY:

Center Applied For: _____ Referral Source: _____

Verifications:

_____ 1040 Tax Statement
_____ 1040A Tax Statement
_____ _____ Tax Statement
_____ W2 Statement
_____ Pay Stub
_____ Income Declaration
_____ Public Assistance Form
_____ Unemployment
_____ Child Support
_____ Foster Care
_____ SSI
_____ Homeless

_____ DOB

_____ Special Needs:
_____ Applicable
_____ Not Applicable

_____ Immunization Record

_____ Is Child Early Head Start Eligible

Staff Signature: _____ Date: _____/_____/_____
ERSEA Specialist

Application Contact Log:

Date:	**Contact:**