Sarpy County Cooperative Head Start
701 Olson Dr. Suite 111
Papillion, NE 68046
402-339-6592

Dear Parent/Guardian,

Enclosed find an application for Sarpy County Cooperative Head Start. Head Start is a federally funded program for families who meet the eligibility guidelines, with children age birth to five and pregnant women. The only requirements for eligibility are age, income, and residency in Sarpy County.

The program options that are available include:
Head Start *(3 or older by July 31st)*

- *Preschool (3.5 hours/4 days per week) no transportation.*
- *Preschool (6.5 hours per day/8:00-2:30) no transportation provided and parents must be employed or attending school.*

Early Head Start *(younger that 3 by July 31st)*

- *Home-based: A Parent Child Educator comes to the home once a week for 1.5 hours to work with both the parent and child on child development activities.*
- *Center based: (7.5 hours per day/7:30-3:00) no transportation provided and parents must be employed or attending school.*
- *Pregnant Women: Services to pregnant women during the pregnancy and services to the child after delivery.*

Please complete the application packet and return it to the Head Start office. In order for the application to be processed you will need to submit the following information:

- ***Income Verification:*** *Tax return-1040 (preferred).*
  Other documentation-one of the following: W-2, TANF or SSI, past 12 months of pay stubs, letter from employer on company letterhead (must state the hours worked, hourly salary, date of employment, and include the name and phone number of the company).
  Submit all income including child support and unemployment payments. Applicants might be requested to provide additional documentation in order to accurately determine eligibility.
- ***Child's birth certificate***
- ***Address verification:*** *Any current bill or lease with mailing address (applicants must reside in Sarpy County).*
- ***Child's immunization record***

Copies of your information will be made at the office. Office hours are Monday-Friday 8:00 a.m.- 4:30 p.m. Please contact the office to assure that a staff member is available to assist you.

Thank you,

Audra Oestreich
Child and Family Services Manager

Sarpy County Cooperative Head Start Application & Family Member Information **page 1**

Applicant #1

First	Middle	Last	Suffix	Nickname	Birth Date	Gender
					____/____/____	M/F

Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐Multi-Racial ☐Other: _____	☐ Yes ☐ No	☐ None ☐ Little ☐ Moderate ☐ Proficient	_____	☐ None ☐ Little ☐ Moderate ☐ Proficient

Program Option: Select one

Head Start (3 or older) **NO TRANSPORTATION**

_____Preschool (3.5 hours/4 days per week) OR _____Preschool (6.5 hours per day) parents must be employed or attending school

Early Head Start (younger than 3)

_____Home-based: A Parent Child Educator comes to the home weekly for 1.5 hours to work with both the parent and child.

_____Center based: (7.5 hours per day) parents must be working or going to school and no transportation (ages 6 weeks to 3 years)

_____Pregnant Women: Services to pregnant women and to the child after delivery.

Check Primary Health Coverage: ☐ Kid's Connection ☐ Medicaid ☐ Private Insurance ☐ Tri-Care (Military Insurance)
Medicaid Status: ☐ Not Eligible ☐ On Medicaid ☐ Potentially Eligible/Need to Apply

Doctor's Name Address Phone

_____

Dentist's Name Address Phone

_____

Does this child have a disability or special need? ☐ Yes ☐ No **Does this child have an IFSP or IEP?** ☐ Yes ☐ No

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Applicant #2

First	Middle	Last	Suffix	Nickname	Birth Date	Gender
					____/____/____	M/F

Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐Multi-Racial ☐Other: _____	☐ Yes ☐ No	☐ None ☐ Little ☐ Moderate ☐ Proficient	_____	☐ None ☐ Little ☐ Moderate ☐ Proficient

Program Option: Select one

Head Start (3 or older) **NO TRANSPORTATION**

_____Preschool (3.5 hours/4 days per week) OR _____Preschool (6.5 hours per day) parents must be employed or attending school

Early Head Start (younger than 3)

_____Home-based: A Parent Child Educator comes to the home weekly for 1.5 hours to work with both the parent and child.

_____Center based: (7.5 hours per day) parents must be working or going to school and no transportation (ages 6 weeks to 3 years)

_____Pregnant Women: Services to pregnant women and to the child after delivery.

Check Primary Health Coverage: ☐ Kid's Connection ☐ Medicaid ☐ Private Insurance ☐ Tri-Care (Military Insurance)
Medicaid Status: ☐ Not Eligible ☐ On Medicaid ☐ Potentially Eligible/Need to Apply

Doctor's Name Address Phone

_____

Dentist's Name Address Phone

_____

Does this child have a disability or special need? ☐ Yes ☐ No **Does this child have an IFSP or IEP?** ☐ Yes ☐ No

Primary Adult Information **Applicant Name(s):** _____ **page 2**

First	Middle	Last	Suffix	Nickname	Birth Date	Gender
				_____	____/____/____	M/F

Race

☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐Multi-Racial
☐Other: _____

Hispanic

☐ Yes
☐ No

English Proficiency

☐ None
☐ Little
☐ Moderate
☐ Proficient

Other Language

_____

Other Language Proficiency

☐ None
☐ Little
☐ Moderate
☐ Proficient

Highest Grade Completed

☐ Associate's ☐ Grade 10
☐ Bachelor's ☐ Grade 11
☐ Col. Deg/Train ☐ Grade 12
☐ Col or Adv Train ☐ Less than Grade 9
☐ GED ☐ HS Graduate
☐ Master's

Employment Status

☐ Full Time ☐ Full Time & Training
☐ Part Time ☐ Part Time & Training
☐Seasonal ☐ Training or School
☐ Unemployed ☐ Retired or Disabled

Child's Relationship

☐ Natural/Adopted/Step
☐Grandchild
☐ Niece/Nephew
☐Foster
☐ Other

Custody (child in your care)

☐ Yes
☐ No

Check all that apply: ☐ Lives with Family ☐ Provides Financial Support ☐ Teen Parent (less than 19 years of age at the time of application)

E-mail address: _____

Secondary Adult Information

First	Middle	Last	Suffix	Nickname	Birth Date	Gender
				_____	____/____/____	M/F

Race

☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐Multi-Racial
☐Other: _____

Hispanic

☐ Yes
☐ No

English Proficiency

☐ None
☐ Little
☐ Moderate
☐ Proficient

Other Language

_____

Other Language Proficiency

☐ None
☐ Little
☐ Moderate
☐ Proficient

Highest Grade Completed

☐ Associate's ☐ Grade 10
☐ Bachelor's ☐ Grade 11
☐ Col. Deg/Train ☐ Grade 12
☐ Col or Adv Train ☐ Less than Grade 9
☐ GED ☐ HS Graduate
☐ Master's

Employment Status

☐ Full Time ☐ Full Time & Training
☐ Part Time ☐ Part Time & Training
☐Seasonal ☐ Training or School
☐ Unemployed ☐ Retired or Disabled

Child's Relationship

☐ Natural/Adopted/Step
☐Grandchild
☐ Niece/Nephew
☐Foster
☐ Other

Custody (child in your care)

☐ Yes
☐ No

Check all that apply: ☐ Lives with Family ☐ Provides Financial Support ☐ Teen Parent (less than 19 years of age at the time of application)

E-mail address: _____

Additional Child (Non-Applicant) #1 **Applicant Name(s): _____ page 3**

First	Middle	Last	Suffix	Nickname	Birth Date	Gender
_____				_____	____/____/____	M/F

Child's Relationship	Race		Hispanic	English Proficiency	Other Language: _____
☐ Natural/Adopted/Step	☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ None	**Other Language**
☐Grandchild	☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Little	☐ None
☐ Niece/Nephew	☐ White	☐Multi-Racial		☐ Moderate	☐ Little
☐Foster	☐Other: _____			☐ Proficient	☐ Moderate
☐ Other					☐ Proficient

Additional Child (Non-Applicant) #2

First	Middle	Last	Suffix	Nickname	Birth Date	Gender
_____				_____	____/____/____	M/F

Child's Relationship	Race		Hispanic	English Proficiency	Other Language: _____
☐ Natural/Adopted/Step	☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ None	**Other Language**
☐Grandchild	☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Little	☐ None
☐ Niece/Nephew	☐ White	☐Multi-Racial		☐ Moderate	☐ Little
☐Foster	☐Other: _____			☐ Proficient	☐ Moderate
☐ Other					☐ Proficient

Additional Child (Non-Applicant) #3

First	Middle	Last	Suffix	Nickname	Birth Date	Gender
_____				_____	____/____/____	M/F

Child's Relationship	Race		Hispanic	English Proficiency	Other Language: _____
☐ Natural/Adopted/Step	☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ None	**Other Language**
☐Grandchild	☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Little	☐ None
☐ Niece/Nephew	☐ White	☐Multi-Racial		☐ Moderate	☐ Little
☐Foster	☐Other: _____			☐ Proficient	☐ Moderate
☐ Other					☐ Proficient

Family Information and Contacts **Applicant Name(s):** _____ **page 4**

Family Living Address **Zip** **City** **State** **County**

_____, _____ _____

Total number in family: _____

Family Mailing Address

Same as living: ☐ Yes ☐ No **Mailing Address** **Zip** **City** **State**

_____, _____

Phone Number(s) **Type (check one)** **Note (for example, whose phone, an extension or best time to call)**

_____ ☐ Cell ☐ Home ☐ Work ☐ Other _____

_____ ☐ Cell ☐ Home ☐ Work ☐ Other _____

_____ ☐ Cell ☐ Home ☐ Work ☐ Other _____

Parent Status

☐ One

☐ Two

☐ Other

Primary Language at Home

_____

Homeless Family

☐ Yes ☐ No

Active Military Duty

☐ Yes ☐ No

Referred by Child Welfare Agency

☐ Yes ☐ No

Receiving SNAP

☐ Yes ☐ No

Receiving WIC

☐ Yes ☐ No

Referred by:

☐Brochure/Flyer ☐ Doctor/Dentist
☐ Friend ☐ Newspaper/TV/Radio
☐ Post Card ☐ School District
☐ Other _____

Is the child that you are applying for an immigrant (the child was **NOT** born in the United States)? ☐ Yes ☐ No
If yes, how many years has this child been in the U.S.? ____

Emergency Contacts

Name	**Relationship**	**Emergency Contact**	**Release To**
_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
Address	**City, State, Zip**	**Phone 1**	**Phone 2**
_____	_____	_____	_____
Name	**Relationship**	**Emergency Contact**	**Release To**
_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
Address	**City, State, Zip**	**Phone 1**	**Phone 2**
_____	_____	_____	_____
Name	**Relationship**	**Emergency Contact**	**Release To**
_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
Address	**City, State, Zip**	**Phone 1**	**Phone 2**
_____	_____	_____	_____

Certification: I certify that this information is true. If any part is false, my participation in this agency's program may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency.

If your child(ren) is/are selected for the program you will need to supply the agency with a current Well Child Exam, Dental Exam, Immunization Record, Hemoglobin and Lead Level BEFORE the child enters the program

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

Sarpy County Cooperative Head Start **Child Health and Dental History**

Child's Name: _____ School Year _____

Pregnancy and Birth History **(Circle each answer)**

1. Did mother have any health problems during this pregnancy or during deliver? YES NO
   If yes, please explain:

2. Was mother in the hospital longer than usual? YES NO
   If yes, please explain:

3. Did mother visit health care provider fewer than two times during pregnancy YES NO

4. Was child born more than 3 weeks early or late? YES NO
   If yes, please explain:

5. What was the child's birth weight? _____lbs. _____ oz.

6. Was anything wrong with the child at birth or in the nursery? YES NO
   If yes, please explain:

7. Is mother pregnant now? YES NO
   If so, has prenatal care begun? YES NO

Child's Health History:

8. Has child ever been hospitalized or operated on? YES NO
   If yes, please explain:

9. Has child ever had a serious injury or illness (broken bone, head injury, falls, burns, RSV, etc)? YES NO
   If yes, please explain:

10. Does child have frequent: _____sore throat _____ cough _____ urinary infections/trouble urinating YES NO
    _____ stomach pain ____vomiting/diarrhea

11. Does child have difficulty seeing (squinting, looking closely at books)? YES NO
    If yes, please explain:

12. Is child wearing glasses, or supposed to wear glasses? YES NO
    Date of last exam: _____

13. Does child have problems with ears or hearing (pain in ear, frequent ear infections, etc.) YES NO
    If yes, please explain:

14. Has child ever had a convulsion or seizure? YES NO
    Date of last seizure:_____ Any medication for seizures? _____

15. Is child taking any medication now? YES NO
    Does child need medication at Early Head Start/Head Start? YES NO
    List medication:

16. Has child had: _____ chicken pox _____measles _____German measles _____mumps _____ scarlet fever _____whopping cough
    _____ asthma _____ diabetes _____epilepsy _____heart problems _____ sickle cell _____ liver disease
    _____ eczema _____cancer _____ hives _____boils _____ rheumatic fever eczema
    Please provide any explanations/further information:

17. Does child have any allergy problems? YES NO
    Foods? _____
    Medication? _____
    Environmental? _____

18. Is child currently being treated for any reason by a doctor or a dentist YES NO
    If yes, please explain:

19. Additional Health Comments:

******Please note any child with a history of asthma, allergies, seizure, diabetes or special diet may be required to have additional paperwork completed by their health care provider <u>PRIOR</u> to starting school.***

Revised 11/14/11 **(OVER)**

Child Health Record (page 2)

Lead Screening Risk Questionnaire (Circle each answer)

1. Do you have any reason to believe that your child may have blood lead poisoning?	Yes	No	4. Does your child live on a farm where there are old out-buildings or sheds?	Yes	No
2. Has your child ever been screened for lead?	Yes	No	5. Does your child live in military housing?	Yes	No
3. Does your child live in a house built prior to 1978?	Yes	No	6. Does your child receive Medicaid or Kids Connection?	Yes	No

Dentist's Name: _____ Date of Last Visit: _____

Reason for Last Visit: _____

1. If you do not have a family dentist, would you like a referral? YES NO
2. Has your child ever been seen by a dentist? YES NO
3. Has your child had any injuries to the mouth/teeth/head? YES NO
   If yes, please explain:
4. Is your home connected to: (circle one) WELL WATER CITY WATER

****Children on well water will need information from the dentist regarding fluoride supplements**

5. Does your child engage in any of the following behaviors? (circle any that are applicable)

Thumb sucking Mouth breathing Pacifier Nail biting Bottle

THE BELOW QUESTIONS ARE FOR CHILDREN OVER 1 YEAR OF AGE

Does your child have any unusual speech habits? YES NO
If yes, please explain:

Has your child ever worn orthodontic appliances? YES NO
If yes, please explain:

Does your child brush their teeth two times each day? YES NO

Do you assist your child with tooth brushing or oral hygiene care? YES NO

Do you floss your child's teeth daily? YES NO

Does your child take fluoride? YES NO

_____ _____

Signature of Parent/Guardian **Date**

(OVER)