

EICAP HEAD START

A Program of Eastern Idaho Community Action Partnership



Dear Prospective Head Start Parent:

Thank you for your interest in the Head Start Program. After you have completed the application packet, be sure to provide us with all the necessary information to avoid any delays in processing and accepting your child's application.

PLEASE FOLLOW THE STEPS LISTED BELOW TO ENSURE YOUR APPLICATION IS COMPLETE.

STEP 1

Complete application packet and provide verification of income, age and wellness information (well child exam, oral exam and immunization record). ↓

ONE of the following: Parent's Income Verification

- Income Tax Return (most recent)
- W-2's (most recent)
- Previous 12 months of check stubs with year-to-date wages
- An employer's written statement of income for the previous 12 months

If Applicable, please provide

- Proof of Child Support received
- Scholarship and/or grant award letter(s)
- Documentation of SSI Benefits

We also need copies of:

- Social security card (if applicable)
- Birth Certificate, Crib Card or Birth Record (Child must be 3 or 4 by September 1st)
- Immunizations

Family Size	Gross Income Guidelines
1	\$10,890
2	14,710
3	18,530
4	22,350
5	26,170
6	29,990
7	33,810
8	37,630



IMPORTANT MESSAGE

Return the following exam forms with your application (forms are attached with this packet).

- Completed *Well Child Exam*
- Completed *Dental exam*
- **Priority will be given to those who complete needed exams**

STEP 2

Please attach the above information to your application packet and return it as soon as possible, Head Start will review the completed application for eligibility enrollment. We will request additional information as needed.

STEP 3

Head Start will contact you once your child has been accepted. You will need to attend a mandatory orientation.

TIP: If you need assistance in finding a doctor or dentist please feel free to contact us at **522-5370 ext 1064**. We have also attached a copy of local doctors and dentists that accept Medicaid. If your child does not have insurance we may be able to assist you.

TRANSPORTATION

EICAP Head Start **does not** provide transportation. We may provide assistance, consistent with our local policy, to help our families find appropriate transportation service for their children to Head Start. In the application process, transportation has no impact on acceptance.

Central Office: 357 Constitution Way, Idaho Falls >>> P.O. Box 51098, Idaho Falls
(208) 522-5370 Ext. 1067 Fax (208) 542-1453

This institution is an equal opportunity provider.



EICAP HEAD START

A Program of Eastern Idaho Community Action Partnership



Application Date: ____/____/____

Child's Name: _____ Birth Date: ____/____/____

Gender: M ____ F ____ Primary Language Spoken: English ____ Spanish ____ Other _____

Home Address: _____
Street address

City State Zip

Mailing address (if different from above): _____
Street address

City State Zip

Phone : (H) _____ (W) _____ (M) _____

Mother's Name _____ Father's Name _____

Child lives with: Mom ____ Dad ____ Both ____ Grandparents ____ Foster Parent ____ Other _____
(who)

Family Yearly Income\$ _____ #in Family ____ # Living in Home ____ #Adults ____ #Children ____

Medical card # _____ Private Insurance _____
Insurance Co. Name & Policy #

Child's doctors full name _____ City _____ Phone _____

Child's dentist full name _____ City _____ Phone _____

Family circumstances that affect the wellbeing of your child/family will be given priority: (Please check ALL that apply)

Custodial grand parent/kinship ____ Adult mental health. ____ Incarcerated Parent. ____ Court appointed services ____ Substance abuse ____

Domestic Violence ____ Deportation ____ Deployed/returning Vet ____ Recent Death of immediate family member ____ Abandonment ____

Recent Divorce (past 12 months) ____ Immediate family member terminal Illness ____ Adult education (less than a GED) ____

(Please explain any of the above checked boxes to better help us meet your family's needs) _____

Is your family currently involved with Child Protection Services? Yes ____ No ____ If yes who is your case worker _____

Are you and your children currently homeless (i.e. living in temporarily shelters, hotels, vehicles; or moving frequently between the homes of relatives & friends)? Yes ____ No ____

Has your Child **been DIAGNOSED** with a disability or CONCERN in: Speech ____ Language ____ Hearing ____ Vision ____
Motor ____ Behavior ____ Health ____ Allergies ____ Other: _____

Does your Child currently have an IEP or IFSP? Yes ____ No ____ Don't Know _____

Do you have any CONCERNS about your child? -----

How did you hear about Head Start? _____

I certify that the information provided on this form is accurate and truthful to the best of my knowledge.

Parent or Guardian Signature _____ Date _____

Staff accepting application _____ Date _____ Center _____

Any and all information obtained on this application will be kept confidential and only with your written permission will info be shared.

**EICAP HEAD START
FAMILY DEMOGRAPHICS**

Eligible Child Name: _____

FAMILY MEMBERS LIVING IN THE HOME

Name	Supporting adult in child's life Yes/No	Head Of Household Yes/No	Relationship to Child	DOB	Gender M or F	Race/ Ethnicity

Phone Number: _____ Work: _____ Message: _____

Address: _____
Street

City State Zip Code

Living Mailing Other: Specify: _____

Mailing if different: _____
Street

City State Zip Code

Primary language: _____ Secondary: _____

English Speaking Ability: Very well Well Not Well Not at all

Childcare outside of Head Start

Does your child attend child care outside of Head Start? Yes ___ No ___ what type of child care?

Partial care: _____ school district: _____ family child care: _____ child care center _____

Do you use full day full year ___ full day part year ___?

Previous Head Start experience

Have you ever applied for Head Start Services? Yes _____ No _____. If yes, please list name of child and place you applied:

_____.

Previous enrollment in a Head Start program? Yes _____ No _____. If yes, please list name of child and place of enrollment:

_____.

OVER----->

The following information will help us understand the demographic make-up of your family. Head Start will work with you and your family to increase awareness and opportunities in your community. Please complete the following for all adult members living in your household.

*** Please check any/all areas that currently apply to the Head & Co-head of the household.*

(Head of Household)

Name _____ Date: _____

Attended Vocational Training, Trade or Business School? <input type="checkbox"/> Yes <input type="checkbox"/> No Received Certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No Person is willing to pursue Additional Education/Job training? <input type="checkbox"/> Yes <input type="checkbox"/> No	Paying Job? <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Seasonal Non agricultural <input type="checkbox"/> Seasonal agricultural <input type="checkbox"/> Employed and in school In Job Training Program <input type="checkbox"/> training Program w/pay <input type="checkbox"/> training program w/o pay	In School? <input type="checkbox"/> Towards high school Diploma/GED <input type="checkbox"/> Trade or business <input type="checkbox"/> Toward college degree <input type="checkbox"/> Toward post graduate degree Participated in Government Training Program? <input type="checkbox"/> JOBS <input type="checkbox"/> JTPA <input type="checkbox"/> Job Corps <input type="checkbox"/> WIA	Unemployed? <input type="checkbox"/> With past employment experience <input type="checkbox"/> With no previous experience Other: <input type="checkbox"/> Homemaker <input type="checkbox"/> Retired <input type="checkbox"/> Unable to work due to disability.
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Highest level of Education completed: _____ Date Completed: _____

(Additional Family member/Co-head of household)

Name _____ Date: _____

Attended Vocational Training, Trade or Business School? <input type="checkbox"/> Yes <input type="checkbox"/> No Received Certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No Person is willing to pursue Additional Education/Job training? <input type="checkbox"/> Yes <input type="checkbox"/> No	Paying Job? <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Seasonal Non agricultural <input type="checkbox"/> Seasonal agricultural <input type="checkbox"/> Employed and in school In Job Training Program? <input type="checkbox"/> Training program w/pay <input type="checkbox"/> Training program w/o pay	In School? <input type="checkbox"/> Towards high school Diploma/GED <input type="checkbox"/> Trade or business <input type="checkbox"/> Toward college degree <input type="checkbox"/> Toward post graduate degree Participated in Government Training Program? <input type="checkbox"/> JOBS <input type="checkbox"/> JTPA <input type="checkbox"/> Job Corps <input type="checkbox"/> WIA	Unemployed? <input type="checkbox"/> With past employment experience <input type="checkbox"/> With no previous experience Other: <input type="checkbox"/> Homemaker <input type="checkbox"/> Retired <input type="checkbox"/> Unable to work due to disability
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Highest level of Education completed: _____ Date Completed: _____

EICAP Head Start
Family composition and resource page

Family Of: _____

Family Type:

- Two parent family
- Single parent family (mother figure only)
- Single parent family (father figure only)
- Single parent family (mother figure only) living with partner
- Single parent family (father figure only) living with partner
- Other relative(s)
- Foster family
- Other family type: Specify _____

Types of Services or Financial Assistance Received (Mark all that apply):

- Medical financial assistance (i.e. Medicaid/Medicare)
- Food Stamps
- Public Assistance/Welfare (i.e. TANF/AFDC)*
- WIC
- Supplemental Security Income (SSI)
- Foster care/Adoption subsidy (head start child)

- No services received
- Unemployment insurance
- Public housing assistance
- Energy program assistance
- EPSDT
- Child support/alimony
- other: Specify _____

*** If Family is receiving Public Assistance, Answer the Following:**

Began receiving services: ____/____/____

Scheduled termination: ____/____/____

Family Applied to Receive Supplemental Security Income (SSI):

- Yes
- No

Housing Payment Arrangement:

- Own housing
- Exchange services for housing
- Receive subsidized housing
- Rent housing
- Make no payment for housing
- other: Specify _____

Type of Housing:

- House
- Mobile home/trailer
- Homeless/no housing
- Migrant Housing
- Apartment
- Community shelter
- Hotel/motel room
- other: _____

Length of Time at Current Address:

- Less than 6 months
- 1 - 2 years
- 6 - 12 months
- More than 2 years

Number of Times Family Moved in the Past 12 Months:

- Family has not moved
- Twice
- Four or more times
- Once
- Three times

Homeless in Past 12 Months (Including currently homeless): Yes

No (Skip to next question)

Length of time homeless:

- Less than 1 month
- 3 - 6 months
- 1 - 3 months
- More than 6 months

Family Currently Has Means of Transportation:

- Yes
- No (End of section)

Primary mode(s) of transportation used (Mark all that apply):

- Private vehicle (car, truck, van)
- Public transportation (bus, subway, taxi)
- Friend's or relative's vehicle
- other:

Family has alternate means of transportation:

- Yes
- No (End of section)

Alternative means of transportation (Mark all that apply):

- Private vehicle (car, truck, van)
- Public transportation (bus, subway, taxi)
- Friend's or relative's vehicle
- other:

At-Enrollment Family Survey

School Year: _____ School Name: _____ Teacher's Name: _____

Child's Name: _____ Parent/Guardian Name(s): _____

Date: _____

DIRECTIONS

Please answer the following questions.

ABOUT YOUR CHILD

1. Does your child have a nickname that you would like us to use? If so, what is it?

2. What are your child's favorite activities?

3. Does your child have a favorite toy? If so, what is it?

4. What are your child's greatest strengths?

5. What are your child's biggest challenges?

6. What concerns, if any, do you have about your child?

7. What would you most like us to know about your child?

8. What are your greatest hopes for your child?

9. What, if any, health conditions does your child have that require classroom modifications?



ABOUT YOUR FAMILY

10. Does your child have any siblings? If so, how many and what are their ages?

11. Which family members are particularly involved or important in your child's life?

12. Is there any other important information that you would like us to know about your family? What?

ABOUT THE PREKINDERGARTEN EXPERIENCE

13. Has your child attended school in the past? If so, was the experience a positive one? Explain.

14. What does your child look forward to this school year?

15. What, if anything, is your child nervous about concerning this school year?

16. What do you most want your child to learn this school year?

OVERALL

17. What else would you like us to know? Do you have any questions we can answer for you?



EICAP HEAD START



Emergency Contacts Form

Only these individuals will be allowed to pick up your child, Siblings must be 13 and older to pick up your child. Please keep this form updated regularly.

DATE COMPLETED: ____/____/____

Head Start Child Name: _____
First Last

Contact Name: _____
First Name Last Name

Relationship to child: _____ Active Contact: Yes No

Address: _____
Street Apt # City

Work #: _____ Home #: _____ Message #: _____

Primary Language Spoken _____ English Speaking Ability: Very Well Well Not Well Not at all

Contact Name: _____
First Name Last Name

Relationship to child: _____ Active Contact: Yes No

Address: _____
Street Apt # City

Work #: _____ Home #: _____ Message #: _____

Primary Language Spoken _____ English Speaking Ability: Very Well Well Not Well Not at all

Contact Name: _____
First Name Last Name

Relationship to child: _____ Active Contact: Yes No

Address: _____
Street Apt # City

Work #: _____ Home #: _____ Message #: _____

Primary Language Spoken _____ English Speaking Ability: Very Well Well Not Well Not at all

Well Child Exam

Please Take this Form to Your Doctor
Favor de Llevar Esta Hoja a su Doctor

Child's Name _____ DOB _____ Exam Date _____

It is a Medicaid EPSDT requirement that a lead screening blood test be performed at 36 months (3&4 yr olds) to determine a lead toxicity level for Medicaid-eligible children. Hematocrit or Hemoglobin done if 5 year old at risk.

What was the lead screen result _____ (1-10 is normal)

What is the blood pressure (normal 90/50) _____ systolic _____ diastolic

Does child have anemia? ___Yes ___No

Does child have hearing difficulties? ___Yes ___No

Does child have vision problems? ___Yes ___No

Do you see any visible cavities? ___Yes ___No

If yes, was child referred to a dentist? ___Yes ___No

Do you have any nutritional/health concerns about this child? ___Yes ___No

Has this child had an hct or hgb test? ___Yes ___No (**11.4 and above is within normal limits for hgb.**) **Results and date.** _____

Are there any conditions that need accommodations in the classroom? (i.e. asthma, allergies, etc.) _____

Are there any medications that need to be dispensed in the classroom? ___Yes ___No
What? _____

Are there any food allergies or sensitivities? ___Yes ___No What? _____

Is this child up to date on a schedule of appropriate preventative and primary health care? ___Yes ___No

Are you serving or will you be serving as this child's doctor (Medical Home)?
___Yes ___No.

Physicians Signature _____

Date _____

Printed Name _____

EICAP/ HEAD START Child Oral Health Assessment

*Please Take This Form to Your Dentist
Favor de Llevar esta Hoja a su Dentista*

Date of Exam ___/___/___ Child's Name: _____ DOB: _____

Completed By: Dentist Name: _____ Phone: _____

Assessment Type: Initial Exam Follow-up

Is this child up to date on a schedule of appropriate preventative and primary dental care? Yes ___ No ___

Are you serving as this child's Dental Home (dentist) Yes ___ No ___

Was Fluoride applied? ___yes ___no

Was cleaning done? ___yes ___no

Was sealant applied? ___yes ___no

Flossing Frequency:

Daily Weekly Occasionally Never

Number of Times per Day Child Brushes Teeth: |__| |__|

Gum Condition:

Normal Swollen Bleeds Easily Infected

Dental Needs:

No Needs Is treatment needed? Cleaning

Date treatment completed _____

Fluoride Supplement Oral Hygiene Instruction

Other: Specify _____

Provider Signature: _____ Date: _____

Print Provider Name: _____

What is a "Medical/Dental Home?"

A medical/dental home is not a building, house, or hospital but an approach to providing health care services in a high-quality and cost-effective manner. In the Medical/Dental home approach, children and their families receive the care they need from a physician or dentist they can trust. Physician, Dentist, and Parents act as partners to identify and access all the medical and non-medical services needed to help children and families achieve their maximum potential.

Head Start believes along with the American Academy of Pediatrics that all children should have a medical/dental home where care is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent.



EASTERN IDAHO COMMUNITY ACTION PARTNERSHIP

P.O. Box 51098
357 Constitution Way
Idaho Falls, Idaho 83405
(208) 522-5391
FAX (208) 522-5453
1-800-632-4813

Dear Head Start Parents,

The State considers Head Start a licensed day care and we are required to have the children's immunizations current and up to date for their age by the first day of school. Failure to provide a copy of your child's immunization could result in your child being dropped from the program.

Thank you for your cooperation in this matter,

Lisa, Health Specialist
(208) 522-5370 ext. 1064



RSVP





EASTERN IDAHO COMMUNITY ACTION PARTNERSHIP

P.O. Box 51098
357 Constitution Way
Idaho Falls, Idaho 83405
(208) 522-5391
FAX (208) 522-5453
1-800-632-4813

Hello Head Start Parents,

The Office of Head Start and the Medicaid Early Periodic Screening Diagnostic Testing (EPSDT) are requiring that a lead screening be completed on our children three and four years of age if they haven't been previously done. We will need written proof from your doctor if the test was performed when your child was younger.

This demands your immediate attention and we insist that it be completed in order to be in compliance with Head Start requirements. Please remind your doctor when you take your child for their Well Child Exam to do the lead screening test. Medicaid will pay for the test.

These locations do lead testing:

Blackfoot:

Blackfoot Medical Center (785-8166)

Toro Family medicine (782-3990)

Idaho Falls:

Community Family Clinic (528-7655)

The Pediatric Center (523-3060)

Idaho Falls Pediatric (522-4600)

Driggs:

Teton Valley Health Clinic 354-2302

Rexburg:

Rexburg Medical Center (356-5401)

Salmon:

Steele Memorial Clinic (208-756-6212)

If you have any questions please contact Lisa, the Health Specialist.

Thank you,

Lisa, Health Specialist
(208) 522-5370 ext. 1064



RSVP



Medicaid Doctors 2009/2010

Blackfoot Medical Center – 785-2600 Fax: 785-1762, 1441 Parkway, Blackfoot

Bingham Memorial Family Clinic 782-2980 Fax: 785-3504, 98 Poplar, Blackfoot

Pocatello Children and Adolescence Clinic -232-1443 Fax: 239-3434 500 S. 11th Ave, Pocatello

Teton Valley Medical Center – 354-2302 Fax: 3548392

Idaho falls Pediatrics – 522-4600 Fax: 552-7521, 2375 Coronado, Idaho Falls

The Pediatric Center – 523-3060 Fax: 523-0028, 3430 Washington Prkwy, Idaho Falls

Shelley Medical Center – 357-7404 Fax: 357-5678, 210 S. Emerson, Shelly

Rigby Community Center – 745-8747 Fax: 745-939, 167 E. 1st S. Rigby

Rexburg Community Center – 359-1770 Fax: 359-1780, 72 E. Main, Rexburg

Dr. Gates, Laughgran, Cottrell – 356-0234 Fax: 656-8440, 36 Professional Plaza, Rexburg

Dr. Reed Ward – 528-8170 Fax: 552-5461, 3360 Washington Prkwy, Idaho Falls

Steel Memorial Clinic – 208-756-6212 Fax: 208-756-6336, 805 Main St., Salmon

Ceder Creek Family – 782-3700 Fax: 782-3765, 98 Poplar, Blackfoot

Dr. Gary Sena, Clay Prince, David Day, Zollinger – 356-5401 Fax: 356-3111, 393 E. 2nd N., Rexburg

Dr. Wallace Baker – 524-6633 Fax: 524-9952, 1880 John Adams, Idaho Falls

Dr. Theresa Johnson – 529-2544 Fax: 529-3771, 1995 E. 17th Suite 5 (behind Community Care)

Greenfield Family Medicine – 356-9100 Fax: 356-9499, 420 E. 4th N., Rexburg

Dr. Wade Christensen – 524-6633 Fax: 524-9952, 1880 John Adams, Idaho Falls

Dr. Tony Roisum 524-3416 Fax: 552-5461, 3360 Washington Prkwy, Idaho Falls

Family First Medical 552-7700, 3614 Washington Prkwy, Idaho Falls

Health and Wellness Center Of Idaho 528-8777, 2001 S. Woodruff (Teton Medical Plaza)

Community Care 529-5252, 1995 E. 17th St., Idaho Falls

St. Anthony Medical Center 624-4402, 430 N.Bridge, St. Anthony

Dr. Hansen 656-8442, 381 E. 4th N, Rexburg

Dr. Mills 356-9666 10 Madison Professional Park, Rexburg

Dr. Toro 782-3990 315 W. Idaho, Blackfoot

Driggs Health Clinic 354-2302, 238 N. 1st E. Driggs

Medicaid Dentists 2009/2010

Anderson Family Dentistry – 785-6833(380 W. Judicial, Blackfoot) Fax: 785-5632

Dr. Dirk Strobel – 356-4400 (59 Professional Plaza, Rexburg) Fax: 356-4215

Dr. Doug Smith – 356-9262 (56 Professional Plaza, Rexburg) Fax: 356-4804

Dr. James Thomason – 356-3012 (74 E. 1 S., Rexburg) Fax: 359-9612

Family Dental Health Center – 529-0120 (200 N. Woodruff, Idaho Falls) Fax: 523-4711

Dr. Zirker Family Dentistry 528-7665 (1801 S. Ammon Rd) Fax: 522-9556

Channing Way Dental – 529-3660)2205 Channing Way, Idaho Falls) Fax: 529-3666 **No New Children at this time.**

Dr. Toenjes, Dr Breeze – 624-3757 (305 E. 5th N. St. Anthony) Fax: 624-4703

West Wind Dental – 745-0400 (143 ½ Main, Rigby) Fax: 745-5005

Dr. Kenneth Rogers – 756-4940 (1007 E. Main, Salmon Fax: 208-756-3381

Legacy Dental 523-0840 Fax: 523-0921 1685 Pancheri, Idaho Falls

Madison Park Dental Center 356-5601 Fax: 356-8788 35 Madison Professional Park, Rexburg.

Mountain River Dental - 787-8100 Fax: 7878101 7726 Lupine Dr. Victor

Dr. Evan Johnson - 522-8854 Fax: 535-0551 1520 Elk Creek Dr. Idaho Falls

Dr. Michael Elison -522-7216 Fax: 529-3851 3656 Washington Parkway, Idaho Falls

Kidds Dental – 478-5437 Fax: 232-5490 716 Yellowstone, Pocatello

Dr. Carl Holm – 233- 2525 Fax: 233-2523 350 E. Cedar St. Pocatello

Family Dental _ 785-2685 Fax: 785-0998 625 W. Bridge, Blackfoot

Madison Clinic Dentistry 359-2345 242 E. Main St. Rexburg

Foothill Dental 529-4484 2205 Channingway, Idaho Falls

Family Dental Center 785-2685 625 W. Bridge, Blackfoot

Dr. Burtenshaw 785-4696 34 S. E Main, Blackfoot

Blackfoot Smiles 785-2255 310 W. Idaho St. Blackfoot

Couch Comfort Dental 524-2300 2110 E. 25 St. Idaho Falls

Stosich Family Dental 522-8061 1400 E. 17th St. Idaho Falls

Dansie Dental 745-1911 130 N1stW, Rigby

Salmon Valley Dental Clinic (208) 756-4940, 1007 Main St., Salmon

Medicaid Eye Doctors 2009/2010

Dr. Dennis Marshall – 785-3063 (745 W. Bridge, Blackfoot) “Exams only”

Dr Stanley Matsuura – 785-7274 (34 SE Main, Ste 101, Blackfoot) “Exams only”

Dr. Leon Peterson – 785-2210 (310 W. Idaho, Blackfoot) “Exams only”

**Dr’s Todd Birch and Jered Birch - 522-5594 (3351 Merlin, Idaho Falls)
624-3231 (45 W. 1N. St. Anthony)**

Dr. Gary Lattimore – 522-6271 (501 S. Woodruff, Idaho Falls) “Exams only”

Bonneville Vision Center – 523-3937 (838 Woodruff, Idaho Falls)

Dr. Shirts

Dr. Hilborn – 529-4367 (1991 W. Broadway, Idaho Falls)

Dr. Alona King – 529-2701 (760 S. Woodruff, Idaho Falls)

Dr’s Archibald and Thueson – 356-4585 (76 Professional Plaza, Rexburg)

Family Vision Center – 356-0881 (24 E. Main, Rexburg)

Dr. Hansen

Dr. Dwight R. Hansen – 745-8773 (225 w. Main, Rigby)

Dr. Bruce Slavin – 208-756-3600 (818 Main Street, Salmon)

Salmon River Vision Clinic – 208-756-4811 (1301 Main Street, Suite 10, Salmon)