



EICAP Head Start Birth to Five Program

935 E. Lincoln Rd, Idaho Falls, ID 83401 Phone: (208) 522-5370 - Fax: (208) 542-1453

EICAP HEAD START BIRTH TO FIVE PROGRAM APPLICATION LETTER

Dear Prospective Parent,

Thank you for your interest in the Early Childhood 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 below to ensure your application is complete.

Step 1: Complete application and provide documents below

-Income Verification - Identifying what you earned for previous 12 months.
*** *One of the following: Most recent tax return, W2, Paystubs or Employer statement***

-Birth Certificate or Crib Card
-Immunization Records
-Oral Exam
-Social Security Card
-Well Child Exam

If applicable, please also provide

Alimony/Divorce Decree	Foster Child Verification	TANF Benefits
Custody Agreement	Child Support	Public Assistance
Protection/No Contact Order	College Grants/Scholarships	Kin-care Benefits
Unemployment Benefits	Social Security Income (SSI/SSD)	

Step 2: Return the completed application to Head Start. Applications can be dropped off or mailed to:

Drop Off
EICAP Head Start
935 E. Lincoln Road
Idaho Falls, ID 83401

Mail To
EICAP Head Start
PO Box 51098
Idaho Falls, ID 83405

Step 3: Once you provide your completed application packet to Head Start, we will review it for eligibility enrollment. We will request additional information as needed.

Step 4: Central Office will contact you once your child has been accepted. You will need to attend a mandatory orientation. Details of the orientation will be provided in the acceptance letter.

If you need assistance with finding a doctor or dentist, please contact our office. If your child does not have insurance, we may be able to assist you. Please call us at 522-5391 ext.1064. Spanish Speaking (208) 522-5370 ext. 1067 or 1061

TRANSPORTATION: EICAP Head Start Birth to Five Program does not provide transportation.

<http://www.eicap.org>

For Office/Center use only
Event/Center:



Program of Eastern Idaho Community Action Partnership

EICAP Head Start Birth to Five Program

935 E. Lincoln Rd, Idaho Falls, ID 83401 Phone: (208) 522-5370 - Fax: (208) 542-1453

HEAD START/ EARLY HEAD START APPLICATION

ALL FIELDS ARE REQUIRED; PLEASE INDICATE N/A OR IF THE INFORMATION REQUESTED IS NOT APPLICABLE

WHICH PROGRAM ARE YOU APPLYING FOR?

Head Start (3-5) **Child must be 3 on or before Sept. 1st** Early Head Start (0-3) (Bonneville, Bingham, Jefferson, Fremont)

CHILD INFORMATION

Full Name: _____ Date of Birth: ____/____/____ Gender: Male Female

Child lives with: Mom Dad Both Parents Grandparents Foster Parents Other: _____

PARENT INFORMATION

Mother's Name: _____ Cell#: _____ Work #: _____

Father's Name: _____ Cell#: _____ Work #: _____

Annual Income: _____ # in Family: _____ # Living in Home: _____ # of Adults: _____ # of Children: _____

CONTACT INFORMATION

Living Address: _____ City: _____ State: _____ Zip: _____

Mailing Address (if different): _____ City: _____ State: _____ Zip: _____

Email Address- Mother: _____ Father: _____

Family Home Phone #: _____

FAMILY CIRCUMSTANCES AFFECTING THE WELLBEING OF YOUR CHILD/FAMILY (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Custodial grandparent/kinship | <input type="checkbox"/> Abandonment | <input type="checkbox"/> Immediate family member terminal illness |
| <input type="checkbox"/> Incarcerated parent | <input type="checkbox"/> Domestic violence | <input type="checkbox"/> Recent death of immediate family member |
| <input type="checkbox"/> Mental health/Substance abuse | <input type="checkbox"/> Premature | <input type="checkbox"/> Recent Divorce / Legal Separation |
| <input type="checkbox"/> Court appointed services | <input type="checkbox"/> Low birth weight | |
| <input type="checkbox"/> Adult Education (less than GED) | <input type="checkbox"/> Teenage Mother (18 or younger) | |
| <input type="checkbox"/> Deployed/Returning Vet | <input type="checkbox"/> Time in NICU | |
| <input type="checkbox"/> Deportation | | |

If you checked Custodial grandparent/kinship, Court Appointed Services, Recent Divorce, you will need to provide documentation.

Please explain any of the above circumstances you checked: _____

Is your family currently involved with Child Protective Services? Yes No - Who is your caseworker? _____

Do you have any Concerns about your child? Yes No - If yes, please explain: _____

Has your child been DIAGNOSED with disability or CONCERN with any of the following (check all that apply):

Speech Language Hearing Vision Motor Behavior Health Allergies Other:

Does your child have an IFSP/IEP? Yes No Don't Know

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

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

Staff Reviewing application: _____ Date: ____/____/____ Center: _____

All information obtained on this application will be kept confidential and only with your written permission can information be shared

Family Demographics

Child's Name: _____

Name (First Last)	Supporting Adult in child's life?	Head of Household?	Relationship to child?	DOB MM/DD/YY	Gender	Ethnicity
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Primary Language: English Spanish Other: _____ Secondary Language: _____

English Fluency: Very Well Well Not Well Not at all

Childcare outside of Head Start - Does your child attend child care outside of Head Start/EHS? Yes No

If yes, what type of child care? Partial care School district Family care Daycare center

Do you use Full day, full year or Full day part year

Has your child (or other children) been enrolled in a Head Start program? Yes No

If yes, please list child/location of enrollment: _____

You will need to sign a release with our EICAP Head Start office so we may retrieve your previous enrollment information.

How did you hear about Head Start? _____

Child's Medical Provider (office/doctor name): _____

Phone: _____

Child's Dentist Provider (office/doctor name): _____

Phone: _____

Insurance Carrier: _____

Policy#: _____

Who may we contact in case of an emergency?

1) Name: _____ Relationship: _____ Phone Number: _____

2) Name: _____ Relationship: _____ Phone Number: _____

The information attached to this application is necessary for EICAP to process your application.

Employment and Education

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 yourself and the co-head of your household. ** Please check all boxes which apply to you

Head of Household Name: _____

Have you graduated High School? Yes No

If no, what is the highest grade completed? 5th – 8th 9th 10th 11th 12th (no diploma)

Vocational Training Have you attended a Trade or Business School? Yes No
Did you receive a certificate? Yes No Are you willing to pursue additional job training? Yes No

Employed

- | | |
|--|--|
| <input type="checkbox"/> Full time | <input type="checkbox"/> Seasonal (agricultural) |
| <input type="checkbox"/> Part-time | <input type="checkbox"/> Student (full time) |
| <input type="checkbox"/> Seasonal (non-agricultural) | <input type="checkbox"/> In job training program |

Unemployed

- | | |
|---|--|
| <input type="checkbox"/> With employment experience | <input type="checkbox"/> Retired |
| <input type="checkbox"/> With <u>No</u> employment experience | <input type="checkbox"/> Due to Disability |
| <input type="checkbox"/> Homemaker | |

Pursuing Education? Are you currently in school? Yes No

What type of school:

- | | |
|---|------------------------------------|
| <input type="checkbox"/> High School/GED | Government Training Program: |
| <input type="checkbox"/> Trade Business Program | <input type="checkbox"/> Jobs |
| <input type="checkbox"/> College Degree | <input type="checkbox"/> JTPA |
| | <input type="checkbox"/> Job Corps |
| | <input type="checkbox"/> WIA |

Co-Head of Household Name: _____

Have you graduated High School? Yes No

If no, what is the highest grade completed. 5th – 8th 9th 10th 11th 12th (no diploma)

Vocational Training Have you attended a Trade or Business School? Yes No
Did you receive a certificate? Yes No
Are you willing to pursue additional job training? Yes No

Employed

- | | |
|--|--|
| <input type="checkbox"/> Full time | <input type="checkbox"/> Seasonal (agricultural) |
| <input type="checkbox"/> Part-time | <input type="checkbox"/> Student (full time) |
| <input type="checkbox"/> Seasonal (non-agricultural) | <input type="checkbox"/> In job training program |

Unemployed

- | | |
|---|--|
| <input type="checkbox"/> With employment experience | <input type="checkbox"/> Retired |
| <input type="checkbox"/> With <u>No</u> employment experience | <input type="checkbox"/> Due to Disability |
| <input type="checkbox"/> Homemaker | |

Pursuing Education? Are you currently in school? Yes No

What type of school:

- | | |
|---|------------------------------------|
| <input type="checkbox"/> High School/GED | Government Training Program: |
| <input type="checkbox"/> Trade Business Program | <input type="checkbox"/> Jobs |
| <input type="checkbox"/> College Degree | <input type="checkbox"/> JTPA |
| | <input type="checkbox"/> Job Corps |
| | <input type="checkbox"/> WIA |

Family Composition and Resources

Child's Name: _____

Family Type

- Two parent family
 Single parent family (mother/mother figure only)
 Single parent family (father/father figure only)
 Single parent (father/father figure only) living with partner
 Single parent (mother/mother figure only) living with partner

Parent Type:

- Biological Family
 Single Grandparent
 Other relatives:
 Foster Family
 Two Grandparents
 Father (Widower)
 Mother (Widow)
 Father and Step Mother
 Mother and Step Father

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
 Upstart
 Supplemental Security Income (SSI)**
 Foster care/adoption subsidy (for Head Start Child) **
 College Grants / Scholarships**
 Unemployment Insurance**
 Public housing assistance
 Energy program assistance
 ICCP
 Child support/alimony**
 No Services Received
 Other: Specify _____

**** You will need to provide documentation for the double star marked services showing how much you received for the previous 12 months. For child support – 12 months history is still required even if the balance is zero.**

If receiving public assistance, when did you begin receiving services: ____/____/____ Scheduled Termination: ____/____/____

Has family applied to receive Supplemental Security Income? Yes No

Type of Housing:

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

Housing Payment Arrangement:

- Own
 Rent
 Make no payments for housing
 Receive subsidized housing
 Exchange Services for Housing
 Other: Specify _____

Length at time at current address: Less than 6 months 6–12 months 1–2 years 2+ years

Number of times family moved within the past 12 months: 0 1 2 3 4+

Has family been homeless in the past 12 months? Yes No (If no, skip to next question)

Length of time homeless? Currently homeless Less than 1 month 1–3 months 3–6 months 6+months

Does family currently have means of transportation? No Yes (mark all that apply)

Personal vehicle Friend/relative's vehicle Public Transportation Other: _____

Does have family have secondary means of transportation? No Yes (mark all that apply)

Personal vehicle Friend/relative's vehicle Public Transportation Other: _____

EICAP HEAD START Emergency Contacts Form

Only these individuals will be allowed to pick up your child. Siblings must be 13 or older to pick up your child. Please keep this form updated regularly. All adults must have photo identification, including parents ****If an adult appears to be under the influence of drugs or alcohol, the child will not be released, and law enforcement will be notified.****

Head Start Child Name: _____
First
Last

DOB: _____

Emergency Contacts					
Contact 1	Name		Relationship	Emergency Contact	Release To
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Address		ZIP	City	State
Language		Phone Number 1		Phone Number 2	
English Spanish Other: _____				<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	
Contact 2	Name		Relationship	Emergency Contact	Release To
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Address		ZIP	City	State
Language		Phone Number 1		Phone Number 2	
English Spanish Other: _____				<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	
Contact 3	Name		Relationship	Emergency Contact	Release To
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Address		ZIP	City	State
Language		Phone Number 1		Phone Number 2	
English Spanish Other: _____				<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	
Additional Emergency Contacts:					
Contact 4	Name		Relationship	Emergency Contact	Release To
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Address		ZIP	City	State
Language		Phone Number 1		Phone Number 2	
English Spanish Other: _____				<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	
Contact 5	Name		Relationship	Emergency Contact	Release To
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Address		ZIP	City	State
Language		Phone Number 1		Phone Number 2	
English Spanish Other: _____				<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	
Contact 6	Name		Relationship	Emergency Contact	Release To
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Address		ZIP	City	State
Language		Phone Number 1		Phone Number 2	
English Spanish Other: _____				<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	

If no authorized person is located within ONE hour of class end time, staff members will contact local law enforcement or child protection to take the child to a safe place. Staff will appropriately prepare the child for this event.

Parent/Guardian Signature _____

Date _____

Well Child Exam

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

It is a Medicaid EPSDT requirement that a lead screening blood test be performed at 12 & 24 months (1 & 2 year olds) to determine a lead toxicity level for Medicaid-eligible children. Hematocrit or Hemoglobin done at 7-9 months and at 15 & 30 months if at risk

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

Parent's Name: _____ Exam Date: ____/____/____

1 Week 1 Month 2 Month 4 Month 6 Month 9 Month 12 Month
 15 Month 18 Month 24 Month 30 Month 36 Month 4 years 5 years

MEDICAL SERVICES RESULTS

Date: (if different from exam date)

Lead Screening _____ Normal Abnormal Not Examined ____/____/____

Blood Pressures ____/____ Normal Abnormal Not Examined

Blood Count HGB _____ HCT _____ Normal Abnormal Not Examined

Were immunizations given today? Yes No (If yes, please attach current immunization record)

HEALTH STATUS Does child have any of the following conditions (please check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma (respiratory issues) | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Chronic Infections (ear, sinus, etc.) | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Iron Deficiency |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Stomach Ache | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Hearing Issues/Tubes | <input type="checkbox"/> Diabetes | |

Please explain any conditions identified above or list anything conditions not mentioned above:

- Yes No Was child referred to a dentist?
 Yes No Do you have any nutritional/health concerns about this child?
 Yes No Are there medications that need to be dispensed in the classroom?

If yes to any of the above, please explain: _____

- Yes No Is 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)?

Physician Name (Print): _____ Signature: _____

Office Name: _____ Phone Number: _____

Does child have Medicaid or Private Insurance?

Medicaid Private

Insurance Name: _____

Policy Number: _____

Please Remit completed form to: EICAP Head Start • P.O. Box 51098 • Idaho Falls, ID 83401

Fax: (208) 542-1453 • Phone: (208) 522-5370/Center Fax: _____

Date Received: _____

Advocates will send this to "health forms" and upload it to the child's file under Health attachments.

EICAP Head Start Birth to Five Program Oral Assessment

Please take this form to your Dentist
Favor de Llevar esta Hoja a su Dentista

Service Date: _____	Services Rendered: (Please check all that apply)
Child's Name: _____	<input type="checkbox"/> Exam
Child's DOB: _____	<input type="checkbox"/> X-ray
Office Name: _____	<input type="checkbox"/> Child Cleaning/Prophy
Are you serving as this child's Dental Home? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Sealant
Number of times child brushes a day? _____	<input type="checkbox"/> Fluoride
(Please circle one of each of the following.)	*Was a fluoride supplement discussed/prescribed at this appointment? _____
Flossing frequency: Daily Weekly Occasionally Never	<input type="checkbox"/> Oral Hygiene Instruction
Gum Condition: Normal Swollen Bleeds Easily Infected	<input type="checkbox"/> Restorations/Treatments <i>**Please include a treatment plan of work completed during this appointment.</i>
Results of appointment:	
<input type="checkbox"/> Child needs no further work at this time. Six month appointment set: _____	
OR	
<input type="checkbox"/> Further work is needed. <i>Please include a copy of the treatment plan.</i>	
<input type="checkbox"/> Follow up appointment is set for: _____	
<input type="checkbox"/> Anticipated number of appointments to complete treatment: _____	
OR	
<input type="checkbox"/> Treatment discontinued. Please Explain:	

Comments:	

I hereby certify that they services listed above have been performed.

Dentist Signature

Date

Office Phone Number

Please Return to:
EICAP Head Start
P.O. Box 51098
Idaho Falls, Idaho 83405
(208) 522-5370 ext. 1064
Fax: (208) 542-1453/Center Fax: _____



EICAP HEAD START



Eastern Idaho Community Action Partnership

PERMISSION TO RELEASE and/or EXCHANGE CONFIDENTIAL INFORMATION PERMISO PARA HACER PÚBLICO y/o INTERCAMBIAR INFORMACION CONFIDENCIAL

Child's Name: Nombre del Niño/a:		Child DOB: Fecha de Nacimiento:	
<i>I hereby authorize the release and joint sharing of pertinent information from the agency/person listed below: Yo autorizo el intercambio de información pertinente a la agencia/persona nombrada:</i>			
Agency: Agencia:	Eastern Idaho Public Health District		
Phone Number Teléfono:	(208) 522-0310	Fax:	
Address: Dirección:	1250 Hollipark Drive, Idaho Falls, ID 83401		
I authorize the above agency to: Autorizo a la agencia mencionada a:	Audit Child Immunizations Auditoría de Vacunas Para niños		
<i>I understand that the information obtained will be treated in a confidential manner and will not be transmitted to a third party and that <u>it is my right to request a copy of all information and contest any information that I feel is incorrect.</u> This release will be in effect for one year from the date signed below. Yo entiendo que la información obtenido será tratada en una manera confidencial y no será transmitida a una 3era persona y es mi derecho pedir una copia de toda la información. Este permiso se mantendrá en efectivo un ano de la fecha de la firma abajo.</i>			
Parent Signature: Firma del Padre:		Date: Fecha:	
Address & Phone: Dirección & Teléfono:			

Centers/Centros:

Idaho Falls East Head Start 2171 Alan St., Idaho Falls, Idaho 83404 (208)524-1462 Fax: (208)524-7163
 Idaho Falls West Head Start 935 Lincoln Rd., Idaho Falls, Idaho 83401(208)552-0800 Fax: (208)552-3060
 Blackfoot Head Start and Early HS PO Box 1176 Blackfoot, Idaho 83221 (208)782-1064 Fax: (208) 785-7647
 Driggs Head Start 215 North 5th East Driggs, Idaho 83422 (208)354-8233 Fax: (208) 3543-268
 Salmon Head Start 31 Hwy 93 North Suite A, Salmon, Idaho 83467 (208)756-3595 Fax: (208)756-6308
 Rexburg Head Start 55 West 2nd North Rexburg, Idaho 83440 (208)-656-0782 Fax: (208)656-0785
 Hoopes Early Head Start 1465 Hoopes Idaho Falls, Idaho 83401 (208) 542-8170 Fax: (208)534-0101
 Skyline Early Head Start 1755 Blue Sky Dr., Idaho Falls, Idaho 83402 (208)243-8334
 Central Office 935 Lincoln Idaho Falls, Idaho 83401 (208) 522-5370 Fax: (208)542-1453



P.O. Box 51098
935 East Lincoln Road
Idaho Falls, Idaho 83401
(208) 522-5370
FAX (208) 542-1453

Head Start Parents,

As Parents or Guardians, we understand the importance of securing our children's future. Knowing our children are healthy and happy is a big part of that. We know to take our children in for regular well-child and dental exams. However, one important health screening is often forgotten. This test is called a blood lead screening. This detects elevated lead levels in the blood which may indicate lead poisoning. High lead levels can harm your child's growth, behavior and ability to learn.

Children should be screened starting at 12-15 months of age. If not previously tested, children 6 years of age and under should be screened. The blood screening is completed by the child's physician. The test is a simple finger prick to determine the lead level in the blood. If the level is concerning, the physician will indicate further treatment.

Medicaid insurance will generally pay for the blood lead screening for your child and can be performed at a well-child exam.

Talk to your doctor for more information.

If you have any questions, please call the Head Start Health Services Specialist at (208) 522-5370 ext. 1064. Thank you,

Health and Nutrition Advisor
EICAP Head Start Birth to Five Program

