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

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)	SNAP Benefit Letter

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.

OFFICE USE ONLY: ***Date of Intake _____*** ***Client ID#_____*** ***Intake Worker_____***

Eastern Idaho Community Action Partnership

Universal Intake Form

How did you hear about us?

☐ Social Media ☐ Newspaper ☐ Radio ☐ Poster/Flyer ☐ Referred by Family/Friend
☐ Referred by Another Agency ☐ Referred by Utility Company ☐ Other (please state): _____

What EICAP program(s) are you interested in?

☐ Early Head Start ☐ Head Start ☐ Senior Services Information & Assistance ☐ Caregiver Services ☐ Senior Meal Services
☐ Energy Assistance/Crisis ☐ Water Assistance ☐ Food Pantry ☐ Tuition Assistance ☐ Rental Assistance ☐ Weatherization

Household Information			
Name:			
MAILING Address:			
City:		State: IDAHO	Zip Code:
PHYSICAL Address: (If different than mailing address)			
City:	County:	State: IDAHO	Zip Code:
Home Phone:	Cell Phone:	**Ok to contact by text?** ☐ Yes ☐ No	
Email:		**Ok to contact by email?** ☐ Yes ☐ No	
Primary Language:	**Secondary Language:**		
Emergency Contact/Proxy: Name:	Phone #:		

Household Type:

☐ Single Person ☐ Single Parent (Male) ☐ Multi-generational Household
☐ 2 Adults (no kids) ☐ Two Parent Household ☐ Foster Parents
☐ Single Parent (Female) ☐ Nonrelated Adults w/kids ☐ Grand Parents raising Grand Children
☐ Other _____

Current Housing Status:

☐ Stably Housed
☐ At imminent risk of losing housing
☐ At Risk of homelessness
☐ Homeless

Current Housing Situation:

☐ Own ☐ Living/ Staying with another
☐ Rent (No Subsidy) ☐ Emergency Shelter
☐ Rent (Subsidized) ☐ Long Term Care Facility
☐ Place not meant for habitation
☐ Substance abuse treatment facility/ Detox center

Total Number of Household Members

Please provide details regarding those who live in your home on additional pages.

Household Members- ***Please provide details regarding <u>everyone</u> who lives in your home. Pages for additional household members are available.***		
Relationship to Head of Household	Applicant/ Head of Household	2nd Household Member
Name		
Date of Birth		
Social Security # Verified?		
Ethnicity	☐ Hispanic, Latin(a)(o)(x) ☐ Not Hispanic, Latin(a)(o)(x)	☐ Hispanic, Latin(a)(o)(x) ☐ Not Hispanic, Latin(a)(o)(x)
Race	☐ White ☐ Black or African American ☐ American Indian or Alaska Native *Tribal Affiliation*: _____ ☐ Native Hawaiian & Other Pacific Islander ☐ Asian or Asian American ☐ Other _____	☐ White ☐ Black or African American ☐ American Indian or Alaska Native *Tribal Affiliation*: _____ ☐ Native Hawaiian & Other Pacific Islander ☐ Asian or Asian American ☐ Other _____
Gender	☐ Male ☐ Female ☐ Other	☐ Male ☐ Female ☐ Other
U.S. Citizenship	☐ Yes ☐ No ☐ Qualified Alien	☐ Yes ☐ No ☐ Qualified Alien
Military Status	☐ Veteran ☐ Active Military ☐ N/A	☐ Veteran ☐ Active Military ☐ N/A
Disabling Condition	☐ Yes ☐ No	☐ Yes ☐ No
Non-Cash Benefits Please check ALL that Apply)	☐ SNAP (Food Stamps) ☐ WIC ☐ Childcare Voucher ☐ Housing Choice Voucher ☐ Permanent Supportive Housing ☐ HUD-VASH ☐ Affordable Care Act. Subsidy ☐ LIHEAP ☐ Other _____	☐ SNAP (Food Stamps) ☐ WIC ☐ Childcare Voucher ☐ Housing Choice Voucher ☐ Permanent Supportive Housing ☐ HUD-VASH ☐ Affordable Care Act. Subsidy ☐ LIHEAP ☐ Other _____
Health Insurance (Please check ALL that Apply)	☐ Medicaid ☐ State Health Insurance for Adults ☐ Medicare ☐ Private Pay Health Insurance ☐ State Children's Health Insurance Program ☐ Employer Provide Health Insurance ☐ VA Medical Services ☐ Indian Health Service Program ☐ Health Insurance Obtained through COBRA ☐ Other_____	☐ Medicaid ☐ State Health Insurance for Adults ☐ Medicare ☐ Private Pay Health Insurance ☐ State Children's Health Insurance Program ☐ Employer Provide Health Insurance ☐ VA Medical Services ☐ Indian Health Service Program ☐ Health Insurance Obtained through COBRA ☐ Other_____
Education (For those 16+ Check ALL that Apply)	☐ Grades 0-8 ☐ Grades 9-12 / Non-Graduate ☐ High School Graduate ☐ Equivalency Diploma ☐ 12 grade + Some post- Secondary ☐ Graduate of other Post-Secondary school ☐ 2 or 4 year College Graduate	☐ Grades 0-8 ☐ Grades 9-12 / Non-Graduate ☐ High School Graduate ☐ Equivalency Diploma ☐ 12 grade + Some post- Secondary ☐ Graduate of other Post-Secondary school ☐ 2 or 4 year College Graduate
Currently in School? Do you receive scholarships or grants?	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No

Household Members- ***Please provide details regarding <u>everyone</u> who lives in your home. Pages for additional household members are available.***		
Relationship to Head of Household	3rd Household Member	4th Household Member
Name		
Date of Birth		
Social Security # Verified?		
Ethnicity	☐ Hispanic, Latin(a)(o)(x) ☐ Not Hispanic, Latin(a)(o)(x)	☐ Hispanic, Latin(a)(o)(x) ☐ Not Hispanic, Latin(a)(o)(x)
Race	☐ White ☐ Black or African American ☐ American Indian or Alaska Native *Tribal Affiliation*: _____ ☐ Native Hawaiian & Other Pacific Islander ☐ Asian or Asian American ☐ Other _____	☐ White ☐ Black or African American ☐ American Indian or Alaska Native *Tribal Affiliation*: _____ ☐ Native Hawaiian & Other Pacific Islander ☐ Asian or Asian American ☐ Other _____
Gender	☐ Male ☐ Female ☐ Other	☐ Male ☐ Female ☐ Other
U.S. Citizenship	☐ Yes ☐ No ☐ Qualified Alien	☐ Yes ☐ No ☐ Qualified Alien
Military Status	☐ Veteran ☐ Active Military ☐ N/A	☐ Veteran ☐ Active Military ☐ N/A
Disabling Condition	☐ Yes ☐ No	☐ Yes ☐ No
Non-Cash Benefits Please check ALL that Apply)	☐ SNAP (Food Stamps) ☐ WIC ☐ Childcare Voucher ☐ Housing Choice Voucher ☐ Permanent Supportive Housing ☐ HUD-VASH ☐ Affordable Care Act. Subsidy ☐ LIHEAP ☐ Other _____	☐ SNAP (Food Stamps) ☐ WIC ☐ Childcare Voucher ☐ Housing Choice Voucher ☐ Permanent Supportive Housing ☐ HUD-VASH ☐ Affordable Care Act. Subsidy ☐ LIHEAP ☐ Other _____
Health Insurance (Please check ALL that Apply)	☐ Medicaid ☐ State Health Insurance for Adults ☐ Medicare ☐ Private Pay Health Insurance ☐ State Children's Health Insurance Program ☐ Employer Provide Health Insurance ☐ VA Medical Services ☐ Indian Health Service Program ☐ Health Insurance Obtained through COBRA ☐ Other_____	☐ Medicaid ☐ State Health Insurance for Adults ☐ Medicare ☐ Private Pay Health Insurance ☐ State Children's Health Insurance Program ☐ Employer Provide Health Insurance ☐ VA Medical Services ☐ Indian Health Service Program ☐ Health Insurance Obtained through COBRA ☐ Other_____
Education (For those 16+ Check ALL that Apply)	☐ Grades 0-8 ☐ Grades 9-12 / Non-Graduate ☐ High School Graduate ☐ Equivalency Diploma ☐ 12 grade + Some post- Secondary ☐ Graduate of other Post-Secondary school ☐ 2 or 4 year College Graduate	☐ Grades 0-8 ☐ Grades 9-12 / Non-Graduate ☐ High School Graduate ☐ Equivalency Diploma ☐ 12 grade + Some post- Secondary ☐ Graduate of other Post-Secondary school ☐ 2 or 4 year College Graduate
Currently in School? Do you receive scholarships or grants?	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No

Household Members- ***Please provide details regarding <u>everyone</u> who lives in your home. Pages for additional household members are available.***		
Relationship to Head of Household	5th Household Member	6th Household Member
Name		
Date of Birth		
Social Security # Verified?		
Ethnicity	☐ Hispanic, Latin(a)(o)(x) ☐ Not Hispanic, Latin(a)(o)(x)	☐ Hispanic, Latin(a)(o)(x) ☐ Not Hispanic, Latin(a)(o)(x)
Race	☐ White ☐ Black or African American ☐ American Indian or Alaska Native *Tribal Affiliation*: _____ ☐ Native Hawaiian & Other Pacific Islander ☐ Asian or Asian American ☐ Other _____	☐ White ☐ Black or African American ☐ American Indian or Alaska Native *Tribal Affiliation*: _____ ☐ Native Hawaiian & Other Pacific Islander ☐ Asian or Asian American ☐ Other _____
Gender	☐ Male ☐ Female ☐ Other	☐ Male ☐ Female ☐ Other
U.S. Citizenship	☐ Yes ☐ No ☐ Qualified Alien	☐ Yes ☐ No ☐ Qualified Alien
Military Status	☐ Veteran ☐ Active Military ☐ N/A	☐ Veteran ☐ Active Military ☐ N/A
Disabling Condition	☐ Yes ☐ No	☐ Yes ☐ No
Non-Cash Benefits Please check ALL that Apply)	☐ SNAP (Food Stamps) ☐ WIC ☐ Childcare Voucher ☐ Housing Choice Voucher ☐ Permanent Supportive Housing ☐ HUD-VASH ☐ Affordable Care Act. Subsidy ☐ LIHEAP ☐ Other _____	☐ SNAP (Food Stamps) ☐ WIC ☐ Childcare Voucher ☐ Housing Choice Voucher ☐ Permanent Supportive Housing ☐ HUD-VASH ☐ Affordable Care Act. Subsidy ☐ LIHEAP ☐ Other _____
Health Insurance (Please check ALL that Apply)	☐ Medicaid ☐ State Health Insurance for Adults ☐ Medicare ☐ Private Pay Health Insurance ☐ State Children's Health Insurance Program ☐ Employer Provide Health Insurance ☐ VA Medical Services ☐ Indian Health Service Program ☐ Health Insurance Obtained through COBRA ☐ Other_____	☐ Medicaid ☐ State Health Insurance for Adults ☐ Medicare ☐ Private Pay Health Insurance ☐ State Children's Health Insurance Program ☐ Employer Provide Health Insurance ☐ VA Medical Services ☐ Indian Health Service Program ☐ Health Insurance Obtained through COBRA ☐ Other_____
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Currently in School? Do you receive scholarships or grants?	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No

Household Members- ***Please provide details regarding <u>everyone</u> who lives in your home. Pages for additional household members are available.***		
Relationship to Head of Household	7th Household Member	8th Household Member
Name		
Date of Birth		
Social Security # Verified?		
Ethnicity	☐ Hispanic, Latin(a)(o)(x) ☐ Not Hispanic, Latin(a)(o)(x)	☐ Hispanic, Latin(a)(o)(x) ☐ Not Hispanic, Latin(a)(o)(x)
Race	☐ White ☐ Black or African American ☐ American Indian or Alaska Native *Tribal Affiliation*: _____ ☐ Native Hawaiian & Other Pacific Islander ☐ Asian or Asian American ☐ Other _____	☐ White ☐ Black or African American ☐ American Indian or Alaska Native *Tribal Affiliation*: _____ ☐ Native Hawaiian & Other Pacific Islander ☐ Asian or Asian American ☐ Other _____
Gender	☐ Male ☐ Female ☐ Other	☐ Male ☐ Female ☐ Other
U.S. Citizenship	☐ Yes ☐ No ☐ Qualified Alien	☐ Yes ☐ No ☐ Qualified Alien
Military Status	☐ Veteran ☐ Active Military ☐ N/A	☐ Veteran ☐ Active Military ☐ N/A
Disabling Condition	☐ Yes ☐ No	☐ Yes ☐ No
Non-Cash Benefits Please check ALL that Apply)	☐ SNAP (Food Stamps) ☐ WIC ☐ Childcare Voucher ☐ Housing Choice Voucher ☐ Permanent Supportive Housing ☐ HUD-VASH ☐ Affordable Care Act. Subsidy ☐ LIHEAP ☐ Other _____	☐ SNAP (Food Stamps) ☐ WIC ☐ Childcare Voucher ☐ Housing Choice Voucher ☐ Permanent Supportive Housing ☐ HUD-VASH ☐ Affordable Care Act. Subsidy ☐ LIHEAP ☐ Other _____
Health Insurance (Please check ALL that Apply)	☐ Medicaid ☐ State Health Insurance for Adults ☐ Medicare ☐ Private Pay Health Insurance ☐ State Children's Health Insurance Program ☐ Employer Provide Health Insurance ☐ VA Medical Services ☐ Indian Health Service Program ☐ Health Insurance Obtained through COBRA ☐ Other_____	☐ Medicaid ☐ State Health Insurance for Adults ☐ Medicare ☐ Private Pay Health Insurance ☐ State Children's Health Insurance Program ☐ Employer Provide Health Insurance ☐ VA Medical Services ☐ Indian Health Service Program ☐ Health Insurance Obtained through COBRA ☐ Other_____
Education (For those 16+ Check ALL that Apply)	☐ Grades 0-8 ☐ Grades 9-12 / Non-Graduate ☐ High School Graduate ☐ Equivalency Diploma ☐ 12 grade + Some post- Secondary ☐ Graduate of other Post-Secondary school ☐ 2 or 4 year College Graduate	☐ Grades 0-8 ☐ Grades 9-12 / Non-Graduate ☐ High School Graduate ☐ Equivalency Diploma ☐ 12 grade + Some post- Secondary ☐ Graduate of other Post-Secondary school ☐ 2 or 4 year College Graduate
Currently in School? Do you receive scholarships or grants?	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No

Household Monthly Income – *Please provide details regarding everyone in your home that has an income. If there are more household members that cannot be included on this form, please ask for another page.*				
Household Member:	**Applicant/Head of Household**	**2nd Member Name:**	**3rd Member Name:**	**4th Member Name:**
Employment Type (For those 18+ Check ALL that Apply)	☐Full Time ☐ Part Time ☐Self-employed ☐Migrant Seasonal Farm Worker ☐Unemployed < 6 months ☐Unemployed > 6 months ☐Retired ☐Unemployed (Not in Labor Force	☐Full Time ☐ Part Time ☐Self-employed ☐Migrant Seasonal Farm Worker ☐Unemployed < 6 months ☐Unemployed > 6 months ☐Retired ☐Unemployed (Not in Labor Force	☐Full Time ☐ Part Time ☐Self-employed ☐Migrant Seasonal Farm Worker ☐Unemployed < 6 months ☐Unemployed > 6 months ☐Retired ☐Unemployed (Not in Labor Force	☐Full Time ☐ Part Time ☐Self-employed ☐Migrant Seasonal Farm Worker ☐Unemployed < 6 months ☐Unemployed > 6 months ☐Retired ☐Unemployed (Not in Labor Force
Income Sources: *Check all that apply and fill out total monthly income*	☐ No Financial Resources ☐ Earned Income $________________ ☐ Social Security (Retirement/Survivor) $________________ ☐ SSDI $________________ ☐ SSI $________________ ☐ AABD $________________ ☐ VA Benefits $________________ ☐ TANF/TAFI $________________ ☐ Child Support $________________ ☐ Alimony $________________ ☐ Pension/Retirement $________________ ☐ Annuity $________________ ☐ Unemployment $________________ ☐ Workers Compensation $________________ ☐ Private Disability Insurance $________________ ☐ Grandparent Benefit $________________ ☐ Foster Parent Income $________________ ☐ General Assistance $________________ ☐ Interest $________________ ☐ Grants/Scholarships $________________	☐ No Financial Resources ☐ Earned Income $________________ ☐ Social Security (Retirement/Survivor) $________________ ☐ SSDI $________________ ☐ SSI $________________ ☐ AABD $________________ ☐ VA Benefits $________________ ☐ TANF/TAFI $________________ ☐ Child Support $________________ ☐ Alimony $________________ ☐ Pension/Retirement $________________ ☐ Annuity $________________ ☐ Unemployment $________________ ☐ Workers Compensation $________________ ☐ Private Disability Insurance $________________ ☐ Grandparent Benefit $________________ ☐ Foster Parent Income $________________ ☐ General Assistance $________________ ☐ Interest $________________ ☐ Grants/Scholarships $________________	☐ No Financial Resources ☐ Earned Income $________________ ☐ Social Security (Retirement/Survivor) $________________ ☐ SSDI $________________ ☐ SSI $________________ ☐ AABD $________________ ☐ VA Benefits $________________ ☐ TANF/TAFI $________________ ☐ Child Support $________________ ☐ Alimony $________________ ☐ Pension/Retirement $________________ ☐ Annuity $________________ ☐ Unemployment $________________ ☐ Workers Compensation $________________ ☐ Private Disability Insurance $________________ ☐ Grandparent Benefit $________________ ☐ Foster Parent Income $________________ ☐ General Assistance $________________ ☐ Interest $________________ ☐ Grants/Scholarships $________________	☐ No Financial Resources ☐ Earned Income $________________ ☐ Social Security (Retirement/Survivor) $________________ ☐ SSDI $________________ ☐ SSI $________________ ☐ AABD $________________ ☐ VA Benefits $________________ ☐ TANF/TAFI $________________ ☐ Child Support $________________ ☐ Alimony $________________ ☐ Pension/Retirement $________________ ☐ Annuity $________________ ☐ Unemployment $________________ ☐ Workers Compensation $________________ ☐ Private Disability Insurance $________________ ☐ Grandparent Benefit $________________ ☐ Foster Parent Income $________________ ☐ General Assistance $________________ ☐ Interest $________________ ☐ Grants/Scholarships $________________

Household Monthly Income – *Please provide details regarding everyone in your home that has an income. If there are more household members that cannot be included on this form, please ask for another page.*				
Household Member:	**5th Member Name**	**6th Member Name:**	**7th Member Name:**	**8th Member Name:**
Employment Type (For those 18+ Check ALL that Apply)	☐Full Time ☐ Part Time ☐Self-employed ☐Migrant Seasonal Farm Worker ☐Unemployed < 6 months ☐Unemployed > 6 months ☐Retired ☐Unemployed (Not in Labor Force	☐Full Time ☐ Part Time ☐Self-employed ☐Migrant Seasonal Farm Worker ☐Unemployed < 6 months ☐Unemployed > 6 months ☐Retired ☐Unemployed (Not in Labor Force	☐Full Time ☐ Part Time ☐Self-employed ☐Migrant Seasonal Farm Worker ☐Unemployed < 6 months ☐Unemployed > 6 months ☐Retired ☐Unemployed (Not in Labor Force	☐Full Time ☐ Part Time ☐Self-employed ☐Migrant Seasonal Farm Worker ☐Unemployed < 6 months ☐Unemployed > 6 months ☐Retired ☐Unemployed (Not in Labor Force
Income Sources: *Check all that apply and fill out total monthly income*	☐ No Financial Resources ☐ Earned Income $____________ ☐ Social Security (Retirement/Survivor) $____________ ☐ SSDI $____________ ☐ SSI $____________ ☐ AABD $____________ ☐ VA Benefits $____________ ☐ TANF/TAFI $____________ ☐ Child Support $____________ ☐ Alimony $____________ ☐ Pension/Retirement $____________ ☐ Annuity $____________ ☐ Unemployment $____________ ☐ Workers Compensation $____________ ☐ Private Disability Insurance $____________ ☐ Grandparent Benefit $____________ ☐ Foster Parent Income $____________ ☐ General Assistance $____________ ☐ Interest $____________ ☐ Grants/Scholarships $____________	☐ No Financial Resources ☐ Earned Income $____________ ☐ Social Security (Retirement/Survivor) $____________ ☐ SSDI $____________ ☐ SSI $____________ ☐ AABD $____________ ☐ VA Benefits $____________ ☐ TANF/TAFI $____________ ☐ Child Support $____________ ☐ Alimony $____________ ☐ Pension/Retirement $____________ ☐ Annuity $____________ ☐ Unemployment $____________ ☐ Workers Compensation $____________ ☐ Private Disability Insurance $____________ ☐ Grandparent Benefit $____________ ☐ Foster Parent Income $____________ ☐ General Assistance $____________ ☐ Interest $____________ ☐ Grants/Scholarships $____________	☐ No Financial Resources ☐ Earned Income $____________ ☐ Social Security (Retirement/Survivor) $____________ ☐ SSDI $____________ ☐ SSI $____________ ☐ AABD $____________ ☐ VA Benefits $____________ ☐ TANF/TAFI $____________ ☐ Child Support $____________ ☐ Alimony $____________ ☐ Pension/Retirement $____________ ☐ Annuity $____________ ☐ Unemployment $____________ ☐ Workers Compensation $____________ ☐ Private Disability Insurance $____________ ☐ Grandparent Benefit $____________ ☐ Foster Parent Income $____________ ☐ General Assistance $____________ ☐ Interest $____________ ☐ Grants/Scholarships $____________	☐ No Financial Resources ☐ Earned Income $____________ ☐ Social Security (Retirement/Survivor) $____________ ☐ SSDI $____________ ☐ SSI $____________ ☐ AABD $____________ ☐ VA Benefits $____________ ☐ TANF/TAFI $____________ ☐ Child Support $____________ ☐ Alimony $____________ ☐ Pension/Retirement $____________ ☐ Annuity $____________ ☐ Unemployment $____________ ☐ Workers Compensation $____________ ☐ Private Disability Insurance $____________ ☐ Grandparent Benefit $____________ ☐ Foster Parent Income $____________ ☐ General Assistance $____________ ☐ Interest $____________ ☐ Grants/Scholarships $____________

Zero Income Declaration - *Please complete if <u>everyone</u> in your household had <u>no</u> income over the previous three months* Note: If your household also declared zero income in the prior year, additional information may be required.
<u>I DECLARE THAT THE GROSS INCOME FOR MY HOUSEHOLD HAS BEEN ZERO FOR THE PREVIOUS 3 MONTHS.</u> I understand that willful misrepresentation and/or concealment of facts can result in criminal and civil penalties. My household's basic living needs for the previous 3 months have been met by: (Give a brief explanation below)

Shelter	**Food**	**Utilities**

Participant Signature		**Date**	

I certify that the information above is correct and true to the best of my knowledge and understand that further verification for EICAP programs may be required for participation in those programs.

By completing this application, I give permission to EICAP to refer my household to any services available with EICAP programs.

Are you willing to make a long-term commitment to share feedback? ☐ Yes ☐ No

Participant Signature		**Date**	

Office Use Only: Verbal Verification ☐ Yes ☐ No Intake for verbal:

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: _____ DOB:_____
First Last

Emergency Contacts

Contact 1

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Address	ZIP	City	State

Language	Phone Number 1	Phone Number 2
English Spanish Other:_____	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work

Contact 2

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Address	ZIP	City	State

Language	Phone Number 1	Phone Number 2
English Spanish Other:_____	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work

Contact 3

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Address	ZIP	City	State

Language	Phone Number 1	Phone Number 2
English Spanish Other:_____	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work

Additional Emergency Contacts:

Contact 4

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Address	ZIP	City	State

Language	Phone Number 1	Phone Number 2
English Spanish Other:_____	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work

Contact 5

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Address	ZIP	City	State

Language	Phone Number 1	Phone Number 2
English Spanish Other:_____	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work

Contact 6

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Address	ZIP	City	State

Language	Phone Number 1	Phone Number 2
English Spanish Other:_____	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ 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)

☐Allergies
☐Asthma (respiratory issues)
☐Anemia
☐Chronic Infections (ear, sinus, etc.)
☐Food Allergies
☐Diarrhea
☐Constipation
☐Vision Problems
☐ Iron Deficiency
☐Seizures
☐Stomach Ache
☐Vomiting
☐ Hearing Issues/Tubes
☐ 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: _____

Child's Name: _____

Child's DOB: _____

Dentist's Name: _____

Office Name: _____

Are you serving as this child's Dental Home?
☐Yes ☐ No

Number of times child brushes a day? _____

Flossing frequency: **(Please check the one that applies)**
☐Daily ☐Weekly ☐Occasionally ☐ Never

Gum Condition: **(Please check all that apply)**
☐Normal ☐Swollen ☐Bleeds Easily ☐Infected

Services Rendered: **(Please check all that apply)**

☐Exam
☐X-ray
☐Child Cleaning/Prophy
☐Sealant
☐Fluoride
*Was a fluoride supplement discussed/prescribed at this appointment? _____
☐Oral Hygiene Instruction
☐Restorations/Treatments ***Please include a treatment plan of work completed during this appointment.***

Results of appointment:

☐Child needs no further work at this time. Six-month appointment set: _____
OR
☐Further work is needed. ***Please include a copy of the treatment plan.***
☐Follow up appointment is set for: _____
☐Anticipated number of appointments to complete treatment: _____
OR
☐Treatment discontinued. Please Explain:
_____
_____

Comments:
_____
_____
_____

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

_____ _____

Dentist Signature **Date**

Please Return to:
EICAP Head Start Health Specialist
P.O. Box 51098
Idaho Falls, Idaho 83405
(208) 522-5370 ext. 608
Fax: (208) 542-1453

Date received _____ 2017

Advocates will send to Data Entry "health forms" then upload to the child's file under Health attachments.

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 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:*			
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 understand that the information obtained will be treated in a confidential manner and will not be transmitted to a third party and that it is my right to request a copy of all information and contest any information that I feel is incorrect. 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.*			
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

EASTERN IDAHO COMMUNITY ACTION PARTNERSHIP
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. 608. Thank you,

Health and Nutrition Advisor
EICAP Head Start Birth to Five Program