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

Dear prospective parent,

Thank you for your interest in EICAP Head Start's Early Childhood Program.

In order for us to be able to begin processing your application, the application document must be complete, including a parent/guardian signature, and all requested documents. Incomplete applications will cause delays in processing, which may affect your child's acceptance into the program. If you have questions about the application or concerns about providing the documentation, please reach out our Data Entry staff at (208) 522-5391 Ext. 602/604.

☐ Signed Completed Application ☐ Income Documentation for the last 12 Months ☐ SS Card or SSN

☐ Well Child and Oral Forms ☐ Immunization Records ☐ Birth Certificate/Crib Card (to prove age)

Documentation of last 12 months income can be shown by turning in one of the following: your most recent tax return, W2, 12 months of pay stubs, statement from your employer, or your most recent SNAP letter. If applicable, we may ask you to provide additional information, including Divorce Decree/Custody Agreement, Protection/No Contact Order, Foster Child verification, SSI/SSD benefits letter, Kin-Care/TANF benefit letter, unemployment benefits, child support, college grants/scholarships and Guardianship paperwork.

Once you have completed the application and gathered the necessary documents it may be dropped off or mailed to:

Drop off:

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

or

a center that is located closest to you

Mail to:

EICAP Head Start
PO Box 51098 Idaho Falls, ID 83405

After your packet is completed and submitted, we will review it for eligibility enrollment and will request additional documentation, if needed. Once we have verified your application is complete your child will be placed on the waiting list and prioritized. As we fill slots we will contact you if your child has been accepted. You will need to attend a mandatory orientation which will be scheduled by the center your child has been accepted.

If your child does not have medical insurance, a doctor, or dentist, we may be able to assist you. Call our central office at 208-522-5391.

EICAP Head Start is a parent transport program and is unable to provide transportation.

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

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 ☐ Food Pantry ☐ Medical Assistance ☐ Rental Assistance ☐ Tuition Assistance ☐ Weatherization

Household Information			
Name: Head of Household			
MAILING Address:			
City:		State: IDAHO	Zip Code:
PHYSICAL Address: (If different than mailing address)			
City:	County:	State: IDAHO	Zip Code:
Primary Phone: ☐ Cell ☐ Home ☐ Work		**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 ☐ Two Adults (no kids) ☐ Multi-generational Household
☐ Single Parent (Male) ☐ Two Parent Household ☐ Foster Parents
☐ Single Parent (Female) ☐ Nonrelated Adults w/kids ☐ Grand Parents raising Grand Children
☐ Other _____

Current Housing Status:	**Current Housing Situation:**
☐ Stably Housed	☐ Own ☐ Living/ Staying with another
☐ At imminent risk of losing housing	☐ Rent (No Subsidy) ☐ Emergency Shelter
☐ At Risk of homelessness	☐ Rent (Subsidized) ☐ Long Term Care Facility
☐ Homeless	☐ 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	Head of Household	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 *Please check ALL that Apply*	☐ 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	Household Member	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 *Please check ALL that Apply*	☐ 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	Household Member	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 *Please check ALL that Apply*	☐ 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:	**Head of Household**	**Member Name:**	**Member Name:**	**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:	**Head of Household**	**Member Name:**	**Member Name:**	**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 this section **only** if all household members in your home had no income in the previous month.*
Note: If your household also declared zero income in the prior year, additional information may be required.

I DECLARE THAT THE GROSS INCOME FOR MY HOUSEHOLD HAS BEEN ZERO FOR THE PREVIOUS MONTH.
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 month 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:

Make sure that the Parent /Guardian has signed this page if no signature is present it will delay the processing of the application

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.

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.****

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

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.

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

Thank you,

Health and Nutrition Advisor
EICAP Head Start Birth to Five Program

EQUAL HOUSING OPPORTUNITY
aaa Assistance, Advocacy, Answers on Aging. Area VI Agency on Aging
RSVP
Weatherization Works
HEAD START