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.
*** Most recent tax return, W2, Paystubs, 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.

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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)

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

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
	☐Yes ☐ No	☐Yes ☐ No				
	☐Yes ☐ No	☐Yes ☐ 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.

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

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

☐Full time
☐ Part-time
☐ Seasonal (non-agricultural)
☐Seasonal (agricultural)
☐Student (full time)
☐In job training program

Unemployed

☐With employment experience
☐With No employment experience
☐Homemaker
☐Retired
☐Due to Disability

Pursuing Education? Are you currently in school? ☐Yes ☐No

What type of school:
☐High School/GED
☐Trade Business Program
☐College Degree

Government Training Program:
☐ Jobs
☐ JTPA
☐ Job Corps
☐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

☐Full time
☐ Part-time
☐ Seasonal (non-agricultural)
☐Seasonal (agricultural)
☐Student (full time)
☐In job training program

Unemployed

☐With employment experience
☐With No employment experience
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Pursuing Education? Are you currently in school? ☐Yes ☐No

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☐High School/GED
☐Trade Business Program
☐College Degree

Government Training Program:
☐ Jobs
☐ JTPA
☐ Job Corps
☐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 ☐Foster Family ☐Father (Widower) ☐Father and Step Mother
☐Single Grandparent ☐Two Grandparents ☐Mother (Widow) ☐Mother and Step Father
☐Other relatives:

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

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Type of Housing:

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

Housing Payment Arrangement:
☐Own ☐Make no payments for housing ☐Exchange Services for Housing
☐Rent ☐Receive subsidized 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

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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: _____

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

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.**

DATE COMPLETED:______/_______/_______

Parent Signature_____________________________________

Head Start Child Name:______________________________ **DOB** ___________
First *Last*

Contact Name ***Parent contact information first*** (First and Last)	Relationship to Child	Phone numbers	Language Spoken	Share sensitive child information with	Start Date and/or End Date for contact	
Name: ***Address:*** ***City:*_____________ *State:*_____ *Zip:*_____**		**Home:** **Cell:** **Work:**	☐English ☐Spanish	☐ Yes ☐ No		
Name: ***Address:*** ***City:*_____________ *State:*_____ *Zip:*_____**		**Home:** **Cell:** **Work:**	☐English ☐Spanish	☐ Yes ☐ No		
Name: ***Address:*** ***City:*_____________ *State:*_____ *Zip:*_____**		**Home:** **Cell:** **Work:**	☐English ☐Spanish	☐ Yes ☐ No		
Name: ***Address:*** ***City:*_____________ *State:*_____ *Zip:*_____**		**Home:** **Cell:** **Work:**	☐English ☐Spanish	☐ Yes ☐ No		

*****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.**

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, ID 83404
(208) 524-1462, Fax: (208) 524-7163

Idaho Falls West Head Start
935 Lincoln, Idaho Falls, ID 83401
(208) 552-0800, Fax: (208) 552-3060

Blackfoot Head Start
PO Box 1176, Blackfoot, ID 83221
(208) 782-1064, Fax (208) 785-7647

Driggs Head Start
215 North 5th E., Driggs, ID 83422
(208) 354-8233, (208) 354-3268

Salmon Head Start
31 Hwy 93 N. STE A, Salmon, ID 83467
(208) 756-3595, (208) 756-6308

Rexburg Head Start
55 W 2nd N, Rexburg, ID 83440
(208) 656-0782, Fax (208) 656-0782

Central Office/Oficina Central:
EICAP Head Start
935 Lincoln, Idaho Falls, Idaho 83401
(208) 522-5370 ext. 1067, Fax: (208) 542-1453

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

Height_____ (inches) Weight_____(lb. oz.) Head Circumference_____(cm)

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

Date Received: _____

EICAP Head Start 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:_____

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

Number of times child brushes a day?_____

(Please circle one of each of the following.)

Flossing frequency:
Daily Weekly Occasionally Never

Gum Condition:
Normal Swollen Bleeds Easily Infected

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

☐Exam
☐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 Name (*Print)* Dentist Signature Date

_____

Office Phone Number

Please Return to: EICAP Head Start Health and Nutrition Advisor
P.O. Box 51098
Idaho Falls, Idaho 83405
(208) 522-5370 ext. 1064
Fax: (208) 542-8151

Internal use
Date Received: _____

EASTERN IDAHO COMMUNITY ACTION PARTNERSHIP
P.O. Box 51098
935 East Lincoln Road
Idaho Falls, Idaho 83405
(208) 522-5391
FAX (208) 522-5453
1-800-632-481.3

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.

Locations that do lead testing are:

Blackfoot:	
Blackfoot Medical Center	(208) 785-8166
Toro Family Medicine	(208) 782-3990
Idaho Falls:	
Community Family Clinic	(208) 528-7655
The Pediatric Center	(208) 523-3060
Idaho Falls Pediatric	(208) 522-4600
Driggs:	
Teton Valley Health Clinic	(208) 354-2302
Rexburg:	
Rexburg Medical Center	(208) 356-5401
Seasons Medical	(208) 656-8868
Salmon:	
Steele Memorial Clinic	(208) 756-6212

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