

## FDL HEAD START- THANK YOU FOR YOUR INTEREST IN OUR PROGRAM

\*Following is our process for enrollment:

Fill out application and provide income verification (NOW IS THE TIME TO MAKE HEALTH APPOINTMENTS FOR YOUR CHILD)

1. Staff determines eligibility based on your household income
2. You are notified by letter or phone of your child's acceptance into the program
3. You will receive an enrollment packet and have 3 days to complete and return
4. You MUST provide all required documents listed below within 7 days, or contact the Health Program Manager and provide a schedule of the appointment @ 878-8109

\*Just completing the application DOES NOT MEAN YOUR CHILD HAS A SPOT IN THE PROGRAM

\*Home-based children born after September 1<sup>st</sup> will not be eligible for a Center-based spot until September 1<sup>st</sup> of the following year.

\*YOU WILL BE REQUIRED TO HAVE AN ENTRANCE INTERVIEW BEFORE YOUR CHILD CAN START

Medical documents and other Information that needs to be provided:

- Birth Certificate would be appreciated
- Current Physical within the last year
- Immunizations need to be CURRENT, or on a catch up schedule approved by the physician. If your child is on a catch up schedule: Appointment date needs to be turned in to the Health Program Manager for documentation.
- Dental Exam for children ages 1 yr. and older within the last year
- Lead Screening: this should be completed once after age 1.
- Hemoglobin: yearly starting at age 1.

\*If filling out a Housing form, references and phone numbers will be required.

\*\*\*\* Once your child is accepted into the program, you will have 7 days to provide all documents. If it is not completed and turned in, we will place your child on the waiting list. Please schedule any appointments necessary if it has been longer than 1 year since your child has had any of the above completed\*\*

**Please ask your child's physician to fax immunizations, physical, and dental records to us as soon as possible. Appointment dates will be accepted also. Fax number: 218-878-8115**

1/16, 5/17,5/19, 5/20,4/21

## 2021-2022 Application

Legal Name of Child:		Who does this child live with > 50% ?	
Sex: Male <input type="checkbox"/>	Female <input type="checkbox"/>	Child's Date of Birth:	Child's Age on 9/1/2021:
Child's Home Address:		E-mail address:	
City:	State:	Zip:	County:
Name of Primary Caregiver:		Name of Secondary Caregiver: Parent living in home	
Relationship to Child:		Relationship to Child:	
Phone Number:		Phone Number:	
Additional Phone:		Additional Phone:	

### What Program(s) Are You Interested In For This Child?

Early Head Start (Ages 0-3)	Head Start (Ages 3-5)
<input type="checkbox"/> Early Head Start 7:45-3:15	<input type="checkbox"/> Head Start 7:45-2:00
<input type="checkbox"/> Home Based Program	

\*\*Child **MUST** be 3 by September 1st of 2021 to be eligible for Head Start (ages 3-5)\*\*

### What Is Your Child's Ethnicity? (check all that apply)

<input type="checkbox"/> Asian	<input type="checkbox"/> Native American/Alaskan Native	<input type="checkbox"/> Bi-Racial/Multi-Racial
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Native Hawaiian	
<input type="checkbox"/> Other: _____	<input type="checkbox"/> White	
Is Your Child Hispanic/Latino		<input type="checkbox"/> Yes <input type="checkbox"/> No

My Child Has Tribal Affiliation With: (list tribe)	Name of Person Enrolled:
Person Enrolled: <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandparent	Verified on: _____ By: _____
Birthdate of enrolled family member:	<b>**OFFICE USE ONLY**</b>

### My Child Is Currently Receiving: (check all that apply)

<input type="checkbox"/> Child Care Assistance	<input type="checkbox"/> Supplemental Security Income(SSI)	<input type="checkbox"/> WIC
<input type="checkbox"/> MFIP- Cash Assistance	<input type="checkbox"/> TANF	<input type="checkbox"/> Child Support

**Application MUST be returned to the Head Start Office with Income Verification. Please bring one of the following documents when you return the application:**

- Pay Stub
- Public Assistance ID Number
- W-2
- Tax Forms

**CONTINUED ON BACK**



Is this child currently receiving services for a disability?  Yes  No

Medical       Physical       Emotional       Educational Special Needs

Other: \_\_\_\_\_

Do you have concerns about this child's development?  Yes  No

Speech       Learning       Health       Physical       Emotional

Psychological       Behavioral       Other: \_\_\_\_\_

How many people live in your household (including all adults and children)? \_\_\_\_\_

Live on the reservation       Work on the reservation

Is this child currently in Foster Care?  Yes  No If yes, what county? \_\_\_\_\_

Name of Social Worker? \_\_\_\_\_

My Household currently has NO INCOME:  Yes      \*\*If yes, a No Income Form MUST be filled out\*\*

My Household adult receives a Tribal Per-capita Payment:  Yes  No      Amount: \_\_\_\_\_

Please check ALL that apply for your child. This information will only be used to assist us in determining enrollment priority along with income eligibility

<input type="checkbox"/>	Transitioning Student from Early Head Start to Head Start
<input type="checkbox"/>	Single Parent
<input type="checkbox"/>	Teen Parent
<input type="checkbox"/>	Parent/Guardian(s) in school
<input type="checkbox"/>	Parent/Guardian(s) has at least a part time job
<input type="checkbox"/>	Parent/Guardian(s) needs/wants high school diploma/GED
<input type="checkbox"/>	No prenatal care
<input type="checkbox"/>	Child with serious health issue
<input type="checkbox"/>	Child has history of neglect
<input type="checkbox"/>	Alcohol/drug abuse in child's family
<input type="checkbox"/>	Domestic violence history in child's family
<input type="checkbox"/>	Multiple families under one roof
<input type="checkbox"/>	Family caring for elder in home
<input type="checkbox"/>	Child has identified disability/special need/mental health issue
<input type="checkbox"/>	Family history of diabetes
<input type="checkbox"/>	Other family member has identified special need/behavior/mental health issue
<input type="checkbox"/>	Child of Incarcerated Parent
<input type="checkbox"/>	Head Start Programs Parent on staff

Caregiver filling out application: \_\_\_\_\_  
Signature

Date: \_\_\_\_\_

Please print name: \_\_\_\_\_

Staff Use Only:

Received by: _____	Date: _____
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