COLVILLE TRIBAL HEAD START PROGRAM

Head Start Application Packet

Nespelem Head Start
P.O. Box 150, Nespelem, WA 99155
634-2298 FAX: (509) 634-2788
Inchelium (509) 722-7054 Omak (509) 422-7708 Keller (509) 634-7316

MISSION

The Colville Tribes Head Start is a community program involved in improving the quality of life for children and families. Head Start advocates through partnerships and individualized educational opportunities that will strengthen and preserve the child, their family and community, while maintaining respect to tradition, culture, and heritage. (2015)

CHILD_________________________________ PARENT_____________________________________

DISTRICT_______________________________ SCHOOL YEAR________________________________

The following checklist will assist the program in monitoring your application to completion. Your application will be processed when all applicable items have been received with complete information and signature.

REQUIRED ITEMS	CHECK	DATE COMPLETED
1. Immunization Record	_______	________________________
2. Certification of Indian Blood (Tribal Enrollment)	_______	________________________
3. Income Verification	_______	________________________
4. Medical Verification Card	_______	________________________
5. Birth Certificate	_______	________________________

RECOMMENDED ITEMS		
1. Physical Exam	_______	________________________
2. Dental Exam	_______	________________________

I, hereby, attest that all documents included in my child's application are true and accurate and the information I provided on each page, from pages 1-6, contain information that provides for my child's eligibility. I understand and agree with all policies outlined as true statements. All documents REQUIRED ITEMS complete my child's file.

Parent Signature: ____________________________________ **Completed** Date:____________________

Head Start Staff Signature:_____________________________ **Completed** Date:____________________

COLVILLE TRIBES HEAD START
APPLICATION

CHILD INFORMATION		
Name	DOB	Gender
Tribe/Descendant:	Enrollment#:	What Language(s) does your child speak?
Other Claimed Ethnicity: ( ) Hispanic ( ) Asian ( ) African ( ) Hawaiian Native American ( ) Caucasian ( ) Multi-Racial		
The child listed lives with: __Mother __ Father __Both __Other (specify):___________________		

PARENT/GUARDIAN INFORMATION					
Primary Adult			**Secondary Adult**		
Relationship to child:			**Relationship to child:**		
Custody:			**Custody:**		
Name (First, Middle, Last):			Name (First, Middle, Last):		
Mailing Address:			Mailing Address:		
Physical Address/Location:			*Physical Address/Location:*		
City:	State:	ZIP Code:	City:	State:	ZIP Code:
Cell Phone:	Opt in for text messages: ( ) Yes ( ) No		Cell Phone:	Opt in for text messages: ( ) Yes ( ) No	
Home Phone:	Email optional:		Home Phone:	Email optional:	
DOB:	Tribe Enrolled:		DOB:	Tribe Enrolled:	

EDUCATION LEVEL	
Check the Highest Completed ( ) Grade 9 or less ( ) Grade 10 ( ) Grade 11 ( ) High School Diploma ( ) GED	Check the Highest Completed ( ) Grade 9 or less ( ) Grade 10 ( ) Grade 11 ( ) High School Diploma ( ) GED
( ) AA Degree ( ) BA Degree ( ) Master's Degree/Field: College or Advanced Training: 1 2 3 4yr	( ) AA Degree ( ) BA Degree ( ) Master's Degree/Field: College or Advanced Training: 1 2 3 4yr
Are you currently in school? ( ) Yes ( ) No If yes: ( ) Part time ( ) Full time School:_____________________	Are you currently in school? ( ) Yes ( ) No If yes: ( ) Part time ( ) Full time School:_____________________

EMPLOYMENT	
Are you currently working? ( ) Yes ( ) No ( ) Working Full Time ( ) Working Part Time Occupation:_____________________ Name of Employer:_____________________ ( ) Seasonally Employed ( ) Unemployed ( ) Retired ( ) Disabled	Are you currently working? ( ) Yes ( ) No ( ) Working Full Time ( ) Working Part Time Occupation:_____________________ Name of Employer:_____________________ ( ) Seasonally Employed ( ) Unemployed ( ) Retired ( ) Disabled

COLVILLE TRIBES HEAD START / CHILD HEALTH HISTORY

PREGNANCY/BIRTH HISTORY	YES	NO	EXPLAIN ANSWER
Any problems during pregnancy or delivery?			
Did mother take any drugs or use alcohol during pregnancy?			
Was child born more than three weeks early or late?			
What was child's birth weight?			
Was anything wrong with child at birth, or during first month?			

MEDICAL HOME

Does your child have Medical Insurance? ( ) Yes ( ) No
Type: ( ) Apple Health/Provider One ( ) I.H.S. ( ) Private ( ) Other: :____________
Does your child have a regular doctor? ( ) Yes ( ) No If yes, name of Doctor/Clinic :________________________

DENTAL HOME

Does your child have Dental Insurance? ( ) Yes ( ) No If yes, name of Insurance Plan :_____________________
Does your child have a regular dentist? ( ) Yes ( ) No
If yes, name of Dentist/Clinic :______________________________________

DEVELOPMENTAL

Do you think your child has a disability/developmental delay/Speech Concern? ( ) Yes ( ) No
Does your child have any of the following? ( ) IEP ( ) IFSP ( ) Diagnosed Disability:____________________
Provider/School District :_____________________

PHYSICAL HEALTH PROBLEMS OR CONCERNS:

Do you have any concerns for your CHILD? Please check all those that apply

	Physical Health		Hearing	Life threatening conditions*(Asthma, Allergies, Diabetes, Seizures, etc.)
	Dental		Nutrition/ Eating	
	Vision		Low Iron	***A written note from your Doctor is REQUIRED***
	Behavior		Previous High Lead test	

FAMILY HEALTH HISTORY	YES	NO	EXPLAIN ANSWER
Does parent guardian or other children have a disability?			
Does anyone in the family smoke cigarettes?			
Does anyone in the family use alcohol?			
Does anyone in the family have/had a problem with drugs or alcohol?			
Does anyone in the family have diabetes?			
Any other major health conditions in the family?			

FAMILY SOCIAL/EMOTIONAL CONCERNS **Please check all those that apply**

				Additional Information:
	Housing		Drug/Alcohol Issues	Is Family Homeless?
	Job/Employment		Teen Parent	Active Military/Military Veteran?
	Disability/Unable to work		Family Violence	Are you receiving SNAP?
	Food		Incarcerated Parent/Spouse	Are you receiving WIC?
	Legal Issues		Abuse/Neglect	WIC ID#
	Health Issues		CPS/Past-Present	Are you receiving TANF? If no, Previously been on TANF?
	Little or No support from Family or Friends.		Mental Health/ Depression/Post-Partum	Is anyone in your family rec. SSI?

CCT – ECE/Head Start Program
Emergency Information & Consent to Medical Care

Child's Name: ______________________________ DOB: ______________

Parent/Guardian Name: ____

Home: ____________ Mobile: ____________ work: ______________

Parent/Guardian Name: ____

Home: ____________ Mobile: ____________ work: ______________

		Emergency Contact	Release to
Name: ____________________	Phone: ____________________	☐	☐
Name: ____________________	Phone: ____________________	☐	☐
Name: ____________________	Phone: ____________________	☐	☐

CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR CHILDREN

- I hereby give permission that my child may be given emergency treatment to include first aid and CPR by a certified staff member of the Head Start program.
- I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child, by my child's regular physician, or when that physician cannot be reached, by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health and I cannot be contacted.
- In the event of illness or accident, I authorize School designated personnel responsible for this trip to approve Medical Emergency Care for my child. Further, I agree to indemnify and hold harmless Colville Tribes Head Start Program.
- I waive the right to informed consent to such treatment. I also give permission for my child to be transported by ambulance or aide car to an Emergency Center for treatment.

Primary Doctor______________________________ Phone_____________ Clinic__________________

Primary Dental______________________________ Phone_____________ Clinic__________________

Hospital Preference__________________________ Phone_____________

Medical Insurance_____________________ Apple Health: ☐Y ☐N Number:_________________

(attach copy of insurance card)

Child Information:

Prescribed Medications: ____________________________ Tribal Enrollment # ______________________

Allergies (Food, Medication, Etc) ____________________________ Any Medical Condition ______________________

Bus Transportation Information

*Please tell us where your child will be getting on and off the bus daily. Each family is allowed **TWO (2)** permanent changes each year. Transportation will be the responsibility of the parent for temporary or additional changes.*

Morning Pick-Up_________________________ Afternoon Drop-Up_________________________

Phone_________________________ Phone_________________________

[check one]Child Care__Home__Other___ [check one]Child Care__Home__Other___

Parent/Guardian Signature:________________________________ Date: _____________

Head Start Eligibility Verification

2017/2018 COLVILLE TRIBES HEAD START

Please list ALL Family Members:

#	Name of Household Member	Date of Birth	Relationship	Amount of Income (For Office Use Only)	INCOME WORKSHEET (For Office Use Only)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
	TOTAL in Household:			**TOTAL$:**	

For Office Use Only

What document was used to determine eligibility?

- ❑ *Income Tax Form 1040*
- ❑ *W-2*
- ❑ *TANF documentation*
- ❑ *Pay stub or pay envelopes*
- ❑ *Unemployment*
- ❑ *Written statements from employers*
- ❑ *Foster care reimbursement*
- ❑ *SSI documentation*
- ❑ *Income Tax Return*
- ❑ *No Income Statement*
- ❑ *Other Income, please explain*

____

____

APPLICABLE CATEGORY

Check category of eligibility for this child:

- ☐ Public Assistance
- ☐ SSI
- ☐ Homeless
- ☐ Foster Care

Income (Check box that applies)

- ☐ *Below Federal poverty guidelines*
- ☐ *Between 100%-130% of federal guidelines (no more than 35% of enrolled children may fall into this category)*
- ☐ *Over-Income (Counted as part of the 49% maximum for AI/AN programs)*

☐ In Person ☐ By Phone

______________________________ Staff Signature

______________________________ Date of eligibility verification

Colville Tribes Head Start

PERMISSION FOR RELEASE OR OBTAIN INFORMATION

I, hereby, provide the Colville Tribes Head Start consent to obtain and/or share medical/educational/media information with the following agencies in regards to **my child** ____ **DOB**: __________. In granting such permission, I understand that such information will remain confidential and will be used for the benefit of my child. This consent is valid through the child's enrollment with Head Start.

*Please **check** (√) that which applies*.

_____Kindergarten Transition
_____Indian Health Services County Agency (specify: __________________)
_____San Poil Valley Community Health Center
_____Lake Roosevelt Community Health Centers
_____Home Visiting Program
_____Local School District (*specify:* ___________________)
_____WIC (Women's, Infants & Children) Certification Encounter Report
_____STEPS: Diabetes Program
_____Colville Tribal Nutrition Program
_____Tribal Health [CHN, CHR, WIC, Nutritionist/Dietician]
_____Social Security Income
_____TANF (Individual Development Plan)
_____Tribal Enrollment (Certificate of Enrollment & Birth Certificate)
_____Head Start Audit Team
_____Developmental Disabilities Division (DDD)
_____Hospital (Name :___________________)
_____Behavioral Health
_____CPS/CFS/Family Preservation
_____Alcohol Program
_____Private Physician: (_________________)
_____Private Dentist: (_________________)
_____Energy Assistance (LIHEAP, other____________)
_____Food Distribution
_____Social Services
_____Parent Committee
_____Tribal Child Care
_____OTHER:_______________________________________

I, hereby, release the Colville Tribes Head Start and its staff from any legal liability for providing above information. While the child is enrolled with the program, I fully understand that I have the right to review records maintained on my family and to dispute or correct any information I feel is incorrect.

____ _________________ [Year 1: 20_____]
Parent Signature Date

____ _________________ [Year 2: 20_____]
Parent Signature Date