



# NeighborImpact

Critical Needs. Diverse Services. Empowering Change.



Dear Head Start Applicant,

Thank you for your interest in NeighborImpact Head Start. Head Start is a free preschool and family support program that serves children ages three and four from income eligible families. To qualify for the 2009-2010 school year, a child must be born between 9/2/2004 and 9/1/2006.

In order to process your child's application, we will need 12 months of income verification. Please send in **copies** of your income verification. After your income is verified, all income documents you send in with your child's application will be shredded to protect your privacy. If you have any questions regarding proof of income or you are unable to provide documentation, please contact Wendi Skala at 541-548-2380 Ext 143, or by e-mail at [wendis@neighborimpact.org](mailto:wendis@neighborimpact.org) for assistance.

**Please include all of the following that apply for both Parents/Guardians living in the home:**

- Last year's federal tax statement or all of last year's W-2 forms or a December pay stub with the year to date income if this was your only income for the entire year
- Child Support payments received for the last 12 months
- Unemployment payments for the last 12 months
- TANF number and a letter from a DHS caseworker
- For a child in Foster care, a letter from the caseworker
- SSI award letter
- Scholarships/Grant award letter

Please complete this application and turn it along with income verification in as soon as possible. Submitting this application does not ensure enrollment. You will be notified regarding the status of your application as soon as possible.

**Please return the completed application and supporting income documentation in person, or by mail to:**

**ATTN: Head Start  
2303 SW First Street, Redmond, Oregon 97756  
or fax it to (541) 504-5725.**

## 2009-2010 Head Start Application

It is the goal of the NeighborImpact Head Start program to enroll children and families with the greatest need for Head Start services. The information you provide on this application will help NeighborImpact to determine your child's eligibility for Head Start and prioritize your application. All information supplied will be held in strict confidence. If you feel uncomfortable filling out any portion of this application and would like to discuss your situation with a Head Start staff member, please call Paula Smith, Family and Community Partnership Specialist at 548-2380 ext. 129.

### SECTION 1 - CHILD INFORMATION

Legal Name of Child (First Name, Middle Name, Last Name)	Nickname	Birthdate:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Home address:	City	State	Zip Code	County
Child lives with: <input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Legal Guardian(s) <input type="checkbox"/> Foster parent(s) <input type="checkbox"/> Dual Custody <input type="checkbox"/> Other _____				
1. Parent/ Legal Guardian		Relationship to child:		
Mailing address (if different than above)	City	State	Zip Code	County
Phone:	Message number:	Email:		
How should we contact you? <input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email		Best time to contact you:		
2. Parent/ Legal Guardian		Relationship to child:		
Mailing address (if different than above)	City	State	Zip Code	County
Phone:	Message number:	Email:		
How should we contact you? <input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email		Best time to contact you:		
Primary language spoken in the home?	Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what language?			
How well does the child speak English? <input type="checkbox"/> Very well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> Not at all				
Does your child attend childcare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list name, address and phone number of childcare provider/center.				
Is the child receiving services through ECSE (Early Childhood Special Education) or EI (Early Intervention) and currently on an Individualized Family Service Plan (IFSP)? Yes _____ No _____				
In order to serve my child better, I give permission for NeighborImpact Head Start to contact ECSE				
Signature: _____		Date: _____		
Is this child in Foster care? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of caseworker _____				
Please check the box in space provided if family is currently receiving services from the following agencies. Please initial and sign below to give permission for NeighborImpact Head Start to verify receipt of service.				
<input type="checkbox"/> _____ Shelter: <input type="checkbox"/> Bethlehem Inn <input type="checkbox"/> Nancy's House <input type="checkbox"/> House of Hope <input type="checkbox"/> Other (please name) _____ <input type="checkbox"/> _____ Department of Human Services: Which program? <input type="checkbox"/> Self Sufficiency Program <input type="checkbox"/> Child Welfare Program <input type="checkbox"/> _____ Drug Court <input type="checkbox"/> _____ Kids Center <input type="checkbox"/> _____ Mt. Star Relief Nursery <input type="checkbox"/> _____ Ready, Set, Go <input type="checkbox"/> _____ Saving Grace (formerly COBRA) <input type="checkbox"/> _____ Teen Parent Program				
I give permission for NeighborImpact Head Start to contact agencies initialed above on my behalf.				
Signature: _____		Date: _____		

**Need Factors:**

The following questions will help NeighborImpact determine who has the greatest need for Head Start services.

Please let us know if you have a concern or if applying child **currently** has a diagnosed medical, mental health or developmental condition. Please mark all that apply and provide name of doctor or professional who diagnosed, or you are current working with for condition.

ADHD/ADD	<input type="checkbox"/> Concern	<input type="checkbox"/> Diagnosis	Diagnosed by: _____
Alcohol affected at birth	<input type="checkbox"/> Concern	<input type="checkbox"/> Diagnosis	Diagnosed by: _____
Asthma (requiring medication)	<input type="checkbox"/> Concern	<input type="checkbox"/> Diagnosis	Diagnosed by: _____
Autism/Autism Spectrum disorder	<input type="checkbox"/> Concern	<input type="checkbox"/> Diagnosis	Diagnosed by: _____
Communication disorder	<input type="checkbox"/> Concern	<input type="checkbox"/> Diagnosis	Diagnosed by: _____
Developmental Delay	<input type="checkbox"/> Concern	<input type="checkbox"/> Diagnosis	Diagnosed by: _____
Diabetes	<input type="checkbox"/> Concern	<input type="checkbox"/> Diagnosis	Diagnosed by: _____
Drug Affected at birth	<input type="checkbox"/> Concern	<input type="checkbox"/> Diagnosis	Diagnosed by: _____
Eczema (requiring prescription)	<input type="checkbox"/> Concern	<input type="checkbox"/> Diagnosis	Diagnosed by: _____
Emotional/behavioral disorder	<input type="checkbox"/> Concern	<input type="checkbox"/> Diagnosis	Diagnosed by: _____
Food Allergies/Special Diet Needs	<input type="checkbox"/> Concern	<input type="checkbox"/> Diagnosis	Diagnosed by: _____
Hearing Impairment	<input type="checkbox"/> Concern	<input type="checkbox"/> Diagnosis	Diagnosed by: _____
Heart Condition	<input type="checkbox"/> Concern	<input type="checkbox"/> Diagnosis	Diagnosed by: _____
Mental Health Condition	<input type="checkbox"/> Concern	<input type="checkbox"/> Diagnosis	Diagnosed by: _____
Metabolic Disorder	<input type="checkbox"/> Concern	<input type="checkbox"/> Diagnosis	Diagnosed by: _____
Orthopedic impairment	<input type="checkbox"/> Concern	<input type="checkbox"/> Diagnosis	Diagnosed by: _____
Physical impairment	<input type="checkbox"/> Concern	<input type="checkbox"/> Diagnosis	Diagnosed by: _____
Qualifies for Early Childhood Special	<input type="checkbox"/> Concern	<input type="checkbox"/> Diagnosis	Diagnosed by: _____
Seizure disorder (requiring medication)	<input type="checkbox"/> Concern	<input type="checkbox"/> Diagnosis	Diagnosed by: _____
Severe tooth decay - more than 3 missing, filled or decayed teeth	<input type="checkbox"/> Concern	<input type="checkbox"/> Diagnosis	Diagnosed by: _____
Traumatic brain injury	<input type="checkbox"/> Concern	<input type="checkbox"/> Diagnosis	Diagnosed by: _____
Visual impairment	<input type="checkbox"/> Concern	<input type="checkbox"/> Diagnosis	Diagnosed by: _____
Other (please explain)	<input type="checkbox"/> Concern	<input type="checkbox"/> Diagnosis	Diagnosed by: _____

**Other need factors for the child:**

Has the child experienced child abuse (physical or sexual)?  Yes  No

Has the child experienced child neglect?  Yes  No

Has the child experienced or witnessed domestic violence?  Yes  No

Please explain any early childhood trauma your child has experienced.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does anyone living in the home have a diagnosed medical or mental health issue that affects the child applying for Head Start?  
If yes, please explain who has the issue, what the issue is, relation to the child and the affect on child.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Environment issues currently affecting the family (mark all that apply)**

- Court Orders for Protection
- Developmental, physical, or mental disability
- Death of parent of child applying for Head Start
- Death of immediate family member living in household (within 24 months)
- Disaster / tragedy/severe trauma please explain \_\_\_\_\_
- Divorce/Separated (within 24 months)
- Domestic violence
- Family did not have adequate food supply or resources to meet need or prevent hunger in past 30 days
- Homeless (lack a fixed, regular and adequate nighttime residence)
- Incarceration of parent (currently)

- Lack of transportation prevents meeting basic needs
- Literacy issues
- Loss of housing (please explain) \_\_\_\_\_
- Parental substance abuse
- Parole/Probation of parent or household member (please explain) \_\_\_\_\_
- Significant loss of income or employment (please explain) \_\_\_\_\_

**SECTION 2 - FAMILY MEMBERS**

Please use the key provided below and place the number that best describes members in the same household for education, race and ethnicity in the table below. Please list everyone who resides in home including person filling out application and child applying for Head Start.

Education Level*	Race*	Ethnicity:
1) 0-8th grade	1) American Indian or Alaskan Native	1) Hispanic
2) 9-12th grade	2) Asian	2) Non Hispanic
3) High School Diploma or GED	3) Black or African American	
4) 12+ some college	4) Native Hawaiian or Other Pacific Islander	
5) Associate Degree	5) White	
6) Bachelors	6) Bi-racial/Multi-racial	
7) Post Grad	7) Other	
8) Vocational or Grad School		

  

Household Members List all including you (First Name, Middle Initial, Last Name)	Sex	Birthdate	Relationship to child applying for Head Start	***Use above Key for Education	Health Insurance Type (OHP, Private, None)	Disabled Y/N	Veteran Y/N	Person living in home Y/N	***Use above key for Race	***Use above key for Ethnicity

\*\*\*If there are additional family members please document on a separate sheet of paper.

Would you like your child to ride the bus to and from school if available <input type="checkbox"/> Yes <input type="checkbox"/> No	Phone for Bussing Address:			
Address for bussing:	City	State	Zip Code	County

**SECTION 3 - FAMILY COMPOSITION AND RESOURCES**

<p><b>Family Type:</b></p> <input type="checkbox"/> Two parent family <input type="checkbox"/> Joint Custody <input type="checkbox"/> Single mother <input type="checkbox"/> Single mother living with partner <input type="checkbox"/> Single father <input type="checkbox"/> Single father living with partner <input type="checkbox"/> Foster family <input type="checkbox"/> Grandparents raising child(ren) <input type="checkbox"/> Other relative(s) <input type="checkbox"/> Other family type <input type="checkbox"/> Teen Parent (currently 18 years old or younger)	<p><b>Housing:</b></p> <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Homeless (lack a fixed, regular and adequate nighttime residence)	<p><b>Mobility:</b></p> <p>Number of times the family has moved in the past 12 months:</p> <input type="checkbox"/> Family has not moved <input type="checkbox"/> Once <input type="checkbox"/> Twice <input type="checkbox"/> Three <input type="checkbox"/> Four or more times
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<p><b>Type of Housing:</b></p> <input type="checkbox"/> House <input type="checkbox"/> Apartment / Duplex <input type="checkbox"/> Hotel/Motel room <input type="checkbox"/> Mobile Home/Trailer <input type="checkbox"/> Migrant Housing <input type="checkbox"/> Community Shelter <input type="checkbox"/> Other: _____	<p><b>Homelessness:</b></p> <p>Has the family been homeless in past 12 Months?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No (skip to next question) <p>Are you currently homeless?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Length of time homeless:</p> <input type="checkbox"/> Less than 1 month <input type="checkbox"/> 1-3 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> More than 6 Months	<p><b>Transportation:</b></p> <p>Family Currently Has Means of Transportation:</p> <input type="checkbox"/> Yes <input type="checkbox"/> No (skip next questions) <p>Primary mode(s) of transportation used (mark all that apply):</p> <input type="checkbox"/> Private vehicle (car, truck, van) <input type="checkbox"/> Public transportation (BAT, Dial A Ride, taxi) <input type="checkbox"/> Friend's or relative's vehicle <input type="checkbox"/> Other: _____ <p>Family has alternate means of transportation if primary mode(s) are unavailable: <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>
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**Job Status:** Please select appropriate box for parents or guardians of the child.

**Primary Occupation Status:**

<input type="checkbox"/> Paying job	<input type="checkbox"/> In job training program
Full-time <input type="checkbox"/> Mother <input type="checkbox"/> Father	Training program with salary <input type="checkbox"/> Mother <input type="checkbox"/> Father
Part-time - <input type="checkbox"/> Mother <input type="checkbox"/> Father	Training program without salary <input type="checkbox"/> Mother <input type="checkbox"/> Father
Seasonal-Non Agricultural <input type="checkbox"/> Mother <input type="checkbox"/> Father	
Employed and in school <input type="checkbox"/> Mother <input type="checkbox"/> Father	
<input type="checkbox"/> Unemployed <input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> In school
Homemaker <input type="checkbox"/> Mother <input type="checkbox"/> Father	Towards high school diploma/GED <input type="checkbox"/> Mother <input type="checkbox"/> Father
Retired <input type="checkbox"/> Mother <input type="checkbox"/> Father	Towards trade/business qualification <input type="checkbox"/> Mother <input type="checkbox"/> Father
Father	
Unable to work due to disability <input type="checkbox"/> Mother <input type="checkbox"/> Father	Towards college degree <input type="checkbox"/> Mother <input type="checkbox"/> Father

Is anyone in the household a farm worker?  Yes     No

If yes, farm worker status?  Seasonal     Migrant     Farmer

\*\*\*The definition of a farm worker is one who works in connection with cultivating the soil, raising or harvesting any agricultural commodity, or in catching, netting, handling, planting, drying, packing, grading, storing or preserving in its non manufactured state any agricultural commodity.

**Types of services or financial assistance received (please mark all that apply)**

<input type="checkbox"/> Child Support/ Alimony	<input type="checkbox"/> Food Stamps
<input type="checkbox"/> Energy Assistance	<input type="checkbox"/> Financial Aid
<input type="checkbox"/> Foster Care/ Adoption Subsidy	<input type="checkbox"/> Medical financial Assistance (OHP, Medicare)
<input type="checkbox"/> Currently receiving ongoing TANF-Temporary Assistance to Needy Families cash assistance	
<input type="checkbox"/> Public Housing Assistance (HUD...)	<input type="checkbox"/> Supplemental Security Income (SSI)
<input type="checkbox"/> WIC	<input type="checkbox"/> Unemployment Insurance Benefits
<input type="checkbox"/> Other (Please specify) _____	

**Please help us reach other families by letting us know where you heard about Head Start**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Another program of NeighborImpact | <input type="checkbox"/> Child Care Resources              | <input type="checkbox"/> Child Welfare Agency     |
| <input type="checkbox"/> DHS Office                        | <input type="checkbox"/> ECSE                              | <input type="checkbox"/> Family Resource Center   |
| <input type="checkbox"/> Head Start Advertisement          | <input type="checkbox"/> Head Start parent                 | <input type="checkbox"/> Head Start poster        |
| <input type="checkbox"/> Healthy Beginnings                | <input type="checkbox"/> Hospital, Doctor or Health Clinic | <input type="checkbox"/> Other Head Start Program |
| <input type="checkbox"/> Media (Newspaper, Radio,T.V)      | <input type="checkbox"/> Mt Star Relief Nursery            | <input type="checkbox"/> Public School            |
| <input type="checkbox"/> Saving Grace                      | <input type="checkbox"/> WIC                               | <input type="checkbox"/> Other                    |

**Are you currently working with any of the following programs in NeighborImpact?**

**a) Early Care and Education**

- Child Care Resources (referrals, starting child care business, choosing quality care)
- Head Start

**b) Energy Assistance**

- Emergency energy assistance
- Seasonal help with energy bills (LIEAP)
- Energy case management (E2C2)
- Energy education
- Weatherization

**c) Housing**

- Emergency rental assistance
- Family shelter (Nancy's House)
- Transitional housing
- Home TBA (rental assistance for 6-12 months)
- Homeownership
- Housing Counseling

**d) Finances**

- Financial fitness classes
- Starting an IDA match savings account (for education, small business or homeownership)
- Free online tax filing

The information received will be used to evaluate my situation, plan for, and coordinate services for me and my family. I authorize NeighborImpact programs to share and exchange information in the Head Start application about me or my family and my circumstances with one another.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*\*\*\*PLEASE ATTACH PROOF OF INCOME for the last 12 months or last calendar year.**

I certify that the information provided in this application is accurate and truthful to the best of my knowledge, and authorize Head Start to obtain income verification if needed.

\_\_\_\_\_  
Parent/Guardian Signature Date

\_\_\_\_\_  
Parent/Guardian Signature Date

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discrimination on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call, toll free (866) 632-9992 (Voice). TDD users can contact USDA through local relay or the Federal relay at (800) 877-8339 (TDD) or (866)377-8642 (relay voice users). USDA is an equal opportunity provider and employer.

NeighborImpact does not discriminate against any person on the basis of race, color, national origin, disability or age of admission, or participation in its programs services and activities, or in employment. For further information about this policy, or to arrange for an accommodation, contact Human Resources/Section 504 Coordinator, phone number 541- 548-2380 Ext. 115, State Relay 711.

This project is financed in part with 35%, or \$1,509,732 of federal funds, and receives less than 1% of funding in nongovernmental sources.

**OFFICE USE ONLY**

Family Size \_\_\_\_\_ Income \_\_\_\_\_ 12 mo \_\_\_\_\_ Cal Yr. \_\_\_\_\_ Age 9/1 \_\_\_\_\_

Income Verification Used: \_\_\_\_\_ Eligible  Over  \_\_\_\_\_ %

Income Source:  No Income  Pension  TANF  General Assistance  SSI  Unemployment  
 Social Security  Farm Worker  Employment only  Employment + any other source  Other

STAFF SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

STAFF SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_