



NeighborImpact

Critical Needs. Diverse Services. Empowering Change.



NeighborImpact Head Start Application for the 2010-2011 school year

NeighborImpact Head Start offers a free preschool and family support program for children ages three and four. The program offers 128 days of preschool services for three hours and 45 minutes a day, four days a week for 421 children in Crook and Deschutes Counties. The program provides services to children of all abilities including children with disabilities.

To qualify for the 2010-2011 school year, a child must be born between 9/2/2005 and 9/1/2007 and live in Crook or Deschutes County.

It is the goal of NeighborImpact Head Start to enroll children and families with the greatest need for Head Start services. The information you provide in 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 Coordinator at 548-2380 ext. 129 or contact her by email at paulas@neighborimpact.org.

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

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

Please complete this application and turn it, along with income verification, in as soon as possible. Submitting this application does not ensure enrollment.

Applications are prioritized based on need.

You will be notified by mail regarding the status of your application as soon as possible.

2010-2011 Head Start Application

For office use only: C _____ OI _____ I _____

It is the goal of NeighborImpact Head Start to enroll children and families with the greatest need for Head Start services. The information you provide in 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 Coordinator at 548-2380 ext. 129.

SECTION 1 - CHILD INFORMATION

Legal Name of Child (First Name, Middle Name, Last Name)	Nickname	Age:	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"/> Joint Physical 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 EI/ECSE				
Signature: _____		Date: _____		
Is this child in Foster care? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of caseworker _____				
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

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 currently 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: _____
Chronic or terminal illness	<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 or other chronic skin condition	<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
- Chronic or terminal illness
- 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* 1) 0-8th grade 2) 9-12th grade 3) High School Diploma or GED 4) Some college or vocational school 5) Associate degree, 6) Advanced degree or baccalaureate degree	Race* 1) American Indian or Alaskan Native 2) Asian 3) Black or African American 4) Native Hawaiian or Other Pacific Islander 5) White 6) Bi-racial/Multi-racial 7) Other 8) Unspecified	Ethnicity: 1) Hispanic 2) Non Hispanic
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Household Members List all including you (First Name, Middle Initial, Last Name)	Sex	Birthdate Required	Relationship to child applying for Head Start	***Use above Key for Education	Health Insurance Type (OHP, Private, None)	Disabled 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.

SECTION 3 - FAMILY COMPOSITION AND RESOURCES

Family Type: <input type="checkbox"/> Two parent family <input type="checkbox"/> Joint Custody (lives part time with each parent) <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)	Housing: <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Homeless (lack a fixed, regular and adequate nighttime residence)	Type of Housing: <input type="checkbox"/> House <input type="checkbox"/> Apartment/Duplex <input type="checkbox"/> Hotel/Motel <input type="checkbox"/> Mobile Home/Trailer <input type="checkbox"/> Migrant Housing <input type="checkbox"/> Community Shelter <input type="checkbox"/> Other: _____
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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"/> Unemployed |
| Full-time <input type="checkbox"/> Mother <input type="checkbox"/> Father | Receiving Unemployment Benefits <input type="checkbox"/> Mother <input type="checkbox"/> Father |
| Part-time <input type="checkbox"/> Mother <input type="checkbox"/> Father | Retired <input type="checkbox"/> Mother <input type="checkbox"/> Father |
| Seasonal <input type="checkbox"/> Mother <input type="checkbox"/> Father | Homemaker <input type="checkbox"/> Mother <input type="checkbox"/> Father |
| Employed and in school <input type="checkbox"/> Mother <input type="checkbox"/> Father | Unable to work due to disability <input type="checkbox"/> Mother <input type="checkbox"/> Father |
| <input type="checkbox"/> In job training program | <input type="checkbox"/> In school |
| Training program with salary <input type="checkbox"/> Mother <input type="checkbox"/> Father | Towards high school diploma/GED <input type="checkbox"/> Mother <input type="checkbox"/> Father |
| Training program without salary <input type="checkbox"/> Mother <input type="checkbox"/> Father | Towards trade/business qualification <input type="checkbox"/> Mother <input type="checkbox"/> Father |
| | Towards college degree <input type="checkbox"/> Mother <input type="checkbox"/> Father |

Referring Agencies: Please check the box in space provided if family is currently receiving services from any of the following agencies. Please initial and sign below to give permission for NeighborImpact Head Start to verify receipt of service.

- ___ Shelter: Bethlehem Inn Nancy's House House of Hope Other (please name) _____
- ___ Project help
- ___ Department of Human Services program Self Sufficiency Program Child Welfare Program
- ___ Drug Court
- ___ Kids Center
- ___ Mt. Star Relief Nursery
- ___ Healthy Families of the High Desert (formerly Ready, Set, Go)
- ___ Saving Grace (formerly COBRA)
- ___ Teen Parent Program

I give permission for NeighborImpact Head Start to contact agencies initialed above on my behalf.

Signature: _____

Date: _____

SECTION 4 ELIGIBILITY

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

- Employment Income – wages, salary, cash payments, or net income from self employment
- Child Support or Alimony
- Ongoing Cash assistance from Temporary Assistance to Needy Families (TANF)
- Ongoing Employment Related Day Care (ERDC) from TANF
- College or university scholarships, grants, fellowships, and assistantships, or training stipends
- Supplemental Security Income (SSI)
- Unemployment insurance benefits, strike benefits, worker's compensation benefits, veteran's benefits
- Pensions, regular insurance or annuity payments, railroad retirement, military retirement pay
- Regular payments from Social Security or social security death or disability payments (SSDI)
- Periodic receipts from estates or trusts, net rental property income

In order to process your child's application, documentation of categorical eligibility (see below) or 12 months of income verification is needed. Verified income can be from the previous calendar year, or for the preceding 12 months from the date the application is submitted. If you have any questions regarding verification of income or if you are unable to provide income documentation, please contact Wendi Skala, Record Keeping and Monitoring Technician at 541-548-2380 Ext 143, or by email at wendis@neighborimpact.org

Categorical eligibility includes:

- Child in foster care
- Child in family receiving ongoing cash assistance or employment related daycare from Temporary Assistance to Needy Families (TANF)
- Child in family receiving supplemental security income (SSI)
- Child lacks a fixed, regular, and adequate nighttime residence and meets definition of homeless children or youth according to *The McKinney-Vento Homeless Assistance Act*

Please provide documentation of categorical eligibility (see above), or 2009 Federal Tax Return or documentation of all of the following sources of income that apply. Include income documentation for all parents/guardians living in the home. Documentation may be for the previous calendar year (2009) or for the proceeding 12 months. Use the checklist below to ensure that all required documentation is provided.

- Employment Income – wages, salary, cash payments, or net income from self employment
- Child Support or Alimony
- College or university scholarships, grants, fellowships, and assistantships, or training stipends
- Unemployment insurance benefits, strike benefits, worker’s compensation benefits, veteran’s benefits
- Pensions, regular insurance or annuity payments, railroad retirement, military retirement pay
- Regular payments from Social Security or social security death or disability payments (SSDI)
- Periodic receipts from estates or trusts, net rental property income

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

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

Please help us reach other families by letting us know where you heard about NeighborImpact 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 |

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.