ROCK-WALWORTH COMPREHENSIVE FAMILY SERVICES, INC.
HEAD START/EARLY HEAD START APPLICATION PACKET
PROGRAM YEAR…. 2019-2020

Welcome to our Head Start/Early Head Start Program, thank you for your interest in our services. We are a complete early childhood education/family program providing, a positive environment and developmentally appropriate school readiness experiences. Services also include: medical, dental, mental health services, nutrition and parent involvement.

Placement is based on **need**, we are **not** a first come, first served program and all **information** is kept **confidential.**

2018 proof of income and an interview are required as part of the **application process.** Completing the application packet is **not a guarantee** of placement.

PLEASE NOTE: If your child is accepted you will be required to provide/maintain current shot records, annual physical and dental exam (**dental exam** for children ages 3-5 **ONLY**). We can access/print your child's shot record if the shots were given in Wisconsin.

COMPLETE THE PACKET IN BLUE OR BLACK INK ONLY!
DO NOT WAIT TO GET THE HEALTH RECORDS BEFORE SENDING BACK THE APPLICATION.

Please contact us with new address/phone number changes. We can't serve your child if we can't find you!

We are an income based program and will need your exact 2018 income. If you receive one of the following we will need proof of the monthly payment:

♦ **SSI (award letter)** ♦ **Cash assistance (TANF)** ♦ **Foster Care or Kinship Care payment**

If the incomes listed above don't apply to you please send copies of all forms of income listed below, that apply to your family.

- **2018 tax return (sample on the back of this packet OR**
- **2018 W2 Employer Statement or a written statement from the employer**
- **2018 Child Support received for all children in the family**
- **Unemployment Compensation**
- **SSDI or Caretakers Supplement**
- **Written statement from parent for cash received for work**

*** If none of these apply to you please contact the enrollment office***

Please allow up to 30 days for processing the application. Incomplete applications can't be considered for possible placement.

Placement for fall will begin over the summer months.

RWCFS HEAD START/EARLY HEAD START
1221 HENRY AVENUE, BELOIT, WI 53511 608/299-1500 or 1/800/774-7778
FAX: 608/299-1629 (please mail in the original)
E-Mail: jkuchelmeister@cfsheadstart.org or nmarx@cfsheadstart.org

Revised: 3/19

CONFIDENTIAL-APPLICATION FOR ENROLLMENT PY 2019-2020

1221 Henry Ave. – Beloit, WI 53511 608*299*1500 or 1*800*774*7778

THIS APPLICATION SHOULD ONLY BE FILLED OUT AND SIGNED BY THE LEGAL PARENT/GUARDIAN(S)

1

CHILD'S NAME:_____

(AS NAME APPEARS ON BIRTH CERTIFICATE) First, Middle, Last

DATE OF BIRTH: _____ ☐ Female ☐ Male

CHILD'S RACIAL/ETHNIC BACKGROUND (Check **ALL** that apply): ☐ White ☐ Black/African American ☐ Asian

☐ American Indian/Alaska Native ☐Native Hawaiian/Other Pacific Islander ☐ Other: _____ Hispanic/Latino?**(Y/N)**

CHILD'S PRIMARY LANGUAGE: ☐ English ☐ Spanish ☐ American Sign Language ☐ Other:_____

SECONDARY LANGUAGE: ☐ English ☐ Spanish ☐ American Sign Language ☐ Other:_____

PRIMARY LANGUAGE AT HOME: ☐ English ☐ Spanish ☐ American Sign Language ☐ Other:_____

CHILD'S ENGLISH SPEAKING ABILITY? ☐ Very Well ☐ Well ☐ Not Well ☐ Not At All

2

HOME ADDRESS:_____

(Street Address) (Apt/Lot #) (City) (Zip) (County)

MAILING ADDRESS (If different): _____

(P. O. Box #) (City) (Zip) (County)

3

CHILD LIVES PRIMARILY WITH: (Check **ALL** that apply) ☐ Both Parents/Same House ☐ Mother ☐ Father ☐ Legal Step-Parent

☐ Girlfriend ☐ Boyfriend ☐ Grandparent(s) ☐ Foster Parent ☐ Guardian ☐ Other: _____

IS ONE PARENT/GUARDIAN LIVING AWAY FROM HOME ON MILITARY DUTY? ☐ Yes ☐ No

IS MOTHER CURRENTLY PREGNANT? ☐ Yes ☐ No ☐ Unsure **If yes**, when is your due date?_____

HAS FATHER'S PATERNITY BEEN ESTABLISHED? ☐ Yes ☐ No

4

PRIMARY LEGAL PARENT/GUARDIAN: (First, Last) _____**DATE OF BIRTH:**_____

☐ Birth Mom ☐ Birth Dad ☐ Legal Step-parent ☐ Adoptive ☐ Foster ☐ Guardian ☐ Other: _____

STATUS: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

ADDRESS IF DIFFERENT THAN CHILD'S FAMILY? _____

PRIMARY PHONE: _____ **(H/C/W) OPT IN FOR TEXT MESSAGES: (Y/N)**

SECONDARY PHONE: _____ **(H/C/W) E-MAIL ADDRESS:** _____

RACIAL/ETHNIC BACKGROUND: _____ **PRIMARY LANGUAGE:** ☐ English ☐ Spanish ☐ Other _____

ENGLISH SPEAKING ABILITY? ☐ Very Well ☐ Well ☐ Not Well ☐ Not At All

EDUCATION: Did you complete elementary? **(Y/N)** Did you receive? ☐ High school diploma ☐ HSED/GED ☐ None

WORK HISTORY: Did you work in 2018? **(Y/N)** Has your financial situation changed since then? **(Y/N)**

5

SECONDARY LEGAL PARENT/GUARDIAN: (First, Last) _____**DATE OF BIRTH:**_____

☐ Birth Mom ☐ Birth Dad ☐ Legal Step-parent ☐ Adoptive ☐ Foster ☐ Guardian ☐ Other: _____

STATUS: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Deceased

ADDRESS IF DIFFERENT THAN CHILD'S FAMILY? _____

PRIMARY PHONE: _____ **(H/C/W) OPT IN FOR TEXT MESSAGES: (Y/N)**

SECONDARY PHONE: _____ **(H/C/W) E-MAIL ADDRESS:** _____

RACIAL/ETHNIC BACKGROUND: _____ **PRIMARY LANGUAGE:** ☐ English ☐ Spanish ☐ Other _____

ENGLISH SPEAKING ABILITY? ☐ Very Well ☐ Well ☐ Not Well ☐ Not At All

EDUCATION: Did you complete elementary? **(Y/N)** Did you receive? ☐ High school diploma ☐ HSED/GED ☐ None

	WORK HISTORY: Did you work in 2018? **(Y/N)** Has your financial situation changed since then? **(Y/N)**
6	**WHAT IS YOUR CURRENT LIVING ARRANGEMENT?** ☐ Rent ☐ Own ☐ Relative/Friend provides a stable home **WE ARE HOMELESS:** ☐ Yes ☐ No *This means that your family is staying in a car, park, campground, hotel, emergency shelter, staying on the street, transitional housing, or you are temporarily living with another family member or friend.* ***IF HOMELESS PLEASE CHECK WHICH APPLIES:** ☐ Living in cars, parks, camp grounds, public spaces, abandoned buildings or poor quality housing ☐ Motel ☐ Shelter ☐ Mission/Church ☐ Transitional Housing ☐ Stay with family/friends (briefly)
7	**CUSTODY INFORMATION :** ☐ Sole Custody ☐ Shared/joint *Explain Arrangement: _____ (*If 50/50 we will need both parents proof of income.) Physical Placement -Explain who has placement_____ **PLEASE PROVIDE ALL DOCUMENTATION PERTAINING TO CUSTODY AND/OR VISITATION DOCUMENTS.** **Legal documents should contain:** 1) Plaintiff & defendant (parent(s) names) 2) Custody/placement information: and 3) Signature page of the Judge/Family Court Commissioner
8	**PERSON IN THE HOME, (OTHER THAN PARENT/GUARDIAN), AGE 18 OR OLDER TO CONTACT:** (For example: legal step-parent, grandparent, girlfriend/boyfriend, partner) _____ (First) (Last) (Relationship to child) (Phone) (Date Of Birth)
9	**ADDITIONAL CONTACT PERSON(S) IF WE ARE UNABLE TO REACH YOU:** 1._____ (First) (Last) (Relationship to child) (Phone) 2._____ (First) (Last) (Relationship to child) (Phone)
10	**LIST CHILD'S BROTHERS/SISTERS CURRENTLY LIVING IN THE HOME: *USE SPACE ON BACK OF APPLICATION IF NEEDED*** (First) (Last) (Relationship to child) 1._____ ☐ Male ☐ Female Date Of Birth: _____ 2._____ ☐ Male ☐ Female Date of Birth: _____ 3._____ ☐ Male ☐ Female Date of Birth: _____
11	**IS YOUR CHILD CURRENTLY IN?** (Check **All** that apply): ☐ Early Head Start ☐ Head Start ☐ B-3 ☐ Early Childhood/Special Education ☐ Other Home Visitation Program (Please List):_____ ☐ None **WAS YOUR CHILD ON A WAIT LIST LAST YEAR?** ☐ Yes ☐ No **IF YES, WHAT STATE/COUNTY:** _____ **WILL YOU BE SIGNING YOUR 4 YEAR OLD CHILD UP FOR 4K IN THE 19-20 PROGRAM YEAR?** ☐ Yes ☐ No
12	**DOES YOUR CHILD CURRENTLY HAVE: AN IFSP (Birth to 3)?** ☐ Yes ☐ No or **an IEP (Public School)?** ☐ Yes ☐ No **ARE YOU CONCERNED ABOUT ANY OF THE FOLLOWING?** ☐ Yes or ☐ No (If yes, Check **ALL** that apply): ☐ Physical ☐ Health ☐ Learning ☐ Speech/Language ☐ Vision ☐ Hearing ☐ Interacting in a group setting ☐ Emotional ☐ Behavioral ☐ Other/Explain: _____ **DO YOU HAVE ANY FAMILY CONCERNS?** ☐ Yes or ☐ No (If yes, please check **All** that apply): ☐ Reading ☐ Writing ☐ Parent has/had an IEP ☐ Ongoing Education ☐ Transportation ☐ Physical Health ☐ Mental Health ☐ Food ☐ Shelter ☐ Unemployed/Not enough hours ☐ Violence ☐ Alcohol/Drug use ☐ Legal Concerns ☐ One parent is Incarcerated ☐ Both parents are incarcerated ☐ Other/Explain:_____

13 **HAVE YOU BEEN PROFESSIONALLY REFERRED?** ☐ Yes ☐ No (Check **ALL** that apply):

☐ Day Care ☐ Job Center: Rock/Walworth Co. ☐ Counselor ☐ Public School Staff ☐ Birth-3 ☐ Family Resource Center

☐ Community Health Program/WIC ☐ Doctor ☐ Early Head Start/Head Start ☐ Health & Human Services

☐ Teen-Parent connections ☐ Homeless shelter/domestic violence shelter ☐ Other_____

☐ **If nothing above how did you find out about us?** _____

14 **DOES ANY MEMBER OF THE HOUSEHOLD RECEIVE THE FOLLOWING?** (Check **ALL** that apply):

☐ Unemployment ☐ Food Stamps ☐ Health Insurance ☐ WIC/Healthy Start ☐ Public Cash Assistance/W2

☐ SSI- Supplemental Security ☐ SSDI-Social Security Disability ☐ Survivors Benefits ☐ Caretaker Supplement

☐ Public Housing/Section 8 ☐ Energy Assistance ☐ Child Support received for **any** child in the home

☐ Child Care Assistance ☐ Other Income: _____ ☐ None of the above

15 **INCOME VERIFICATION:** Family income is the income of the biological parent(s) /adoptive parent(s) or guardian(s) living in the household.

**** PROOF OF INCOME SHOULD BE RETURNED WITH THE APPLICATION ****

A) TYPES OF INCOME:

1) 2018 Taxes-(See back of application for example) or W-2 2) Unemployment 3) Written statement from employer
4) Cash payments (No Income Form) 5) 2018 Child Support Payments (childsupport.wisconsin.gov or 800/991/5530)

If none of these apply go to letter B

B) OTHER INCOME:

1) Current SSI Award Letter 2) Current TANF (Public Assistance from the County)
3) Current Kinship Care 4) Current Foster Care Payment

* For children receiving Kinship Care/Foster Care, send only the amount you receive for the child's care*

Contact the enrollment office if none of these types of income apply to you.

****PLEASE DO NOT SEND ORIGINALS****

16 **PLEASE PROVIDE WRITTEN INFORMATION IN**: ☐ ENGLISH ☐ SPANISH

17 ****PLEASE READ STATEMENTS BELOW CAREFULLY BEFORE SIGNING****

For enrollment purposes, I understand that RWCFS Head Start-Early Head Start may need to coordinate programming with my local school district, WI Shot Registry, & or day care provider for transportation, placement, 4K registration, scheduling, and other home visitation programs.

By signing, I verify that I am the parent/legal guardian of this child and that the information provided is correct and complete to the best of my knowledge. I further understand that if I knowingly provide false information that my family may no longer be eligible for further services.

SIGN AND DATE:

Parent/Guardian Signature: _____ Date:_____

Parent/Guardian Signature: _____ Date:_____

REMEMBER.. AN INCOMPLETE APPLICATION WILL DELAY PROCESSING-SEE COVER LETTER FOR DETAILS

Non-discriminatory Clause: RWCFS HS&EHS policy is not to discriminate on the basis of race, sex, age, color, national origin, religion, or disabilities in the provision of services and employment**.**

OFFICE USE ONLY:

Pts: _____

Age: _____

Data entered by: (initials) _____

☐ 2ND YR ☐ Transition Application
☐ Transportation Information Form (Blue)
☐ Parent/Guardian Permission for Screenings/Testing
☐ Health/Oral/Nutrition History/Screening ☐ Shots
☐ Income Interview Type: ☐ In Person ☐ Phone Brought In: ☐ 4K App ☐ Legal Papers
☐ Other_____

11. *ADDITIONAL SPACE ON BACK OF APPLICATION IF NEEDED:

PLEASE LIST ANY <u>ADDITIONAL</u> BROTHERS/SISTERS OF CHILD; ONLY THOSE WHO ARE <u>CURRENTLY LIVING</u> IN THE HOME:
(First) (Last) (Relationship to child)

4._____ ☐ Male ☐ Female Date of Birth: _____

5._____ ☐ Male ☐ Female Date of Birth: _____

6._____ ☐ Male ☐ Female Date of Birth: _____

7._____ ☐ Male ☐ Female Date of Birth: _____

8._____ ☐ Male ☐ Female Date of Birth: _____

9._____ ☐ Male ☐ Female Date of Birth: _____

SAMPLE OF FORM NEEDED FROM 2018 TAX RETURN

ROCK-WALWORTH COMPREHENSIVE FAMILY SERVICES INC.

HEAD START AND EARLY HEAD START®
Serving Rock & Walworth Counties

Health/Oral Health/Nutritional History

Child's Name_____ Date of Birth_____
Doctor's Name_____ Clinic Name_____
Name of Family/Child's Dentist_____
Insurance Coverage: □ Private Insurance □ No Medical Coverage □ other: _____

□ **Badger Care/MA: Badger Care card 10-digit number:** _____

Please be advised that Individual Service Plans will be developed for your child in response to any health concerns you share and that need special attention (examples: asthma, allergies, seizures etc.)

1. When did prenatal care begin? _____
2. Were there any significant health concerns during the pregnancy? □ Yes □ No
   Explain: _____
3. What was your due date? _____ Birth Weight: _____ pounds _____ ounces Length: _____
4. Were there medical problems at birth? □ Yes □ No
   Explain: _____
5. At what age did your child get his/her first tooth? _____
   Has your child seen a dentist? □ Yes □ No Do you need help finding a dentist? □ Yes □ No
   Does your child drink fluoridated water? □ Yes □ No
   Does your child use a bottle or sippy cup other than at meal times? □ Yes □ No
   How many times does your child brush his/her teeth per day? **(Circle)** 0 1 2 More
   Does your child get help when brushing his/her teeth? □ Yes □ No
   Has your child had cavities? □ Yes □ No Does your child complain about mouth pain? □ Yes □ No

6. Does anyone in the household smoke? □ Yes □ No
   If yes, would you like information on how and why to quit? □ Yes □ No

7. Has your child been in the hospital or had surgery? □ Yes □ No
   For what? _____ When? _____

8. **Does your child have, or has your child had …**	**History of:**	**Currently:**
Asthma	□ Yes □ No	□ Yes □ No
Disabilities (physical/ sensory/thinking abilities)	□ Yes □ No	□ Yes □ No
Diabetes	□ Yes □ No	□ Yes □ No
Heart Problems	□ Yes □ No	□ Yes □ No
MRSA	□ Yes □ No	□ Yes □ No
Seizures	□ Yes □ No	□ Yes □ No
Sickle Cell Disease	□ Yes □ No	□ Yes □ No
High Lead Level/Lead Poisoning	□ Yes □ No	□ Yes □ No
Other _____	□ Yes □ No	□ Yes □ No

If any marked *yes*, please explain:_____

9. Is child taking daily medications? □ Yes □ No
   If *yes*, please list_____
10. Will medication need to be given while at Head Start/Early Head Start? □ Yes □ No

If yes, we will need a Medication Authorization signed by the doctor and the parent/guardian <u>before</u> any medication can be given to a child.

11. Does child have any vision/eye problems? □ Yes □ No Does child need glasses? □ Yes □ No
12. Does child have hearing/ear problems? □ Yes □ No Currently have tubes? □ Yes □ No

13**. Does your child have any allergies, such as food or medicine? Yes ____ No ____**
If yes, please list:_____
Reaction:_____

Does your child have any dietary restrictions? □ Yes □ No Explain briefly:_____
_____
__

For Children Under 12 Months

1. Type of Milk (Breast or Brand of Formula):_____
2. Amount of breast milk or formula per feeding:_____
3. How often does the child take breast milk or formula (i.e. every how many hours):_____
_____
_
4. Food introduced already (cereal, baby food, table food):_____
_____
_
5. Does the baby take juice (if so, type, amount, and how often):_____

For Children above 12 months

1. **Does this child**

Eat solid food □ Yes □ No Comments:
_____
Drink from a cup □ Yes □ No Comments:
_____
Feed self □ Yes □ No Comments:
_____
Take a bottle □ Yes □ No Comments:
_____
Eat or chew things that aren't food □ Yes □ No Comments: _____
Have trouble chewing or swallowing □ Yes □ No Comments: _____

2. Does your child eat from the following food groups each day?

Food Group	No	Yes
Milk, Yogurt & Cheese Group		
Vegetable Group		
Fruit Group		
Meat, Poultry, Fish, Dry Beans, Eggs & Nuts Group		
Bread, Cereal, Rice and Pasta Group		
Fats, Oils and Sweets		
Water		
My child's favorite food is:		

3. **When does your child eat the most?** □ Breakfast □ Lunch □ Supper □ Snacks □ Eats About the Same 4. **Do you feel your child's eating habits are a problem?** □ Yes □ No
Circle concern: Doesn't eat enough Eats too much Type of food When he/she eats
5. **Are you concerned about your child's weight?** □ Yes □ No
6. **How does your child feel about meal time?** Enjoys meals __ Not interested ___ Needs encouragement ___
7. **Has your child had any problems with?**
Vomiting ____ Diarrhea ____ Constipation ___ Acid Reflux___ Anemia (Low Iron)_____

8. **Is your child physically active for 60 minutes or more?** Daily ____ 2-3 days per week ____ Rarely ____

9. **Are you interested in learning more about nutrition for your family?** □ Yes □ No
   By receiving written material? □ Yes □ No
   By talking with a registered dietician? □ Yes □ No

10. **Are you receiving WIC services?** □ Yes □ No
    If not, may we share your name, address and phone number/s with WIC staff? □ Yes □ No

_____ _____

Parent/Guardian Signature **Date:**

rev: 2/19

ROCK-WALWORTH COMPREHENSIVE FAMILY SERVICES INC.

HEAD START AND EARLY HEAD START - ***Serving Rock & Walworth Counties***

Parent/Guardian Permission to Provide Required or Beneficial Screenings/Testing (2018-2019)

Child's Name: _____
Last Name **First Name** **MI** **Date of Birth**

Name of parent/guardian authorizing release: _____
Last Name **First Name** **MI** **Date of Birth**

In order to meet required Federal Performance Standards, and as schedules and budgets allow, we provide a health, social/emotional and oral health wellness program throughout the year.

RWCFS strives to provide the following services for each participating child. If you would like your child to participate in this program and receive any or all of these services, ***please sign and date for your permission below.***

For the services below, please check *"yes"* or *"no"* if you want your child to participate.

	Yes	No
1. **Hearing and Vision Screenings** provided by local health department nurses or trained RWCFS staff.		
2. **Obtaining *results* of lead and hemoglobin testing** by the Wisconsin Lead Registry database or the local WIC program ***(This does not give permission to perform the testing).***		
3. **Observations and/or social/emotional or sensory screenings** completed by a licensed professional (Mental Health Consultant). **This professional primarily provides observations of children's' behaviors, concerns expressed by staff and provides recommendations to support staff in working effectively with all children.**		
4. **Developmental screenings**		
5. **Blood pressure screenings** provided by trained RWCFS staff or health professionals		

Please fill in your child's insurance card number (if on Badger Care). This information is needed for the community professionals stated above to bill MA and continue these wellness services for our children. Be assured this information will be shared ONLY with the community professionals stated above.

MY CHILD'S BADGER CARD NUMBER IS: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___.

This permission will be valid for the program year stated above or for one year following the date of the signature (whichever is later), unless otherwise stated: _____.
This information is confidential and will be used to support programming which meets this child's unique needs and goals.

I release the Rock-Walworth Head Start/Early Head Start Program and its staff, outside agencies and staff, from any legal liability for performing services in collaboration with community professionals or professional contracted consultants which I have permitted by signing this form for the period stated above. This permission may be withdrawn, in writing, at any time by the person signing this form, except to the extent that service has already been in reliance upon authorization. Withdrawal of the authorization will be effective following receipt of the written request by RWCFS Head Start/Early Head Start.

Signature of Parent/Guardian: _____ Date: _____

(Rev. 2-19)