



ROCK-WALWORTH COMPREHENSIVE FAMILY SERVICES, INC.
HEAD START/EARLY HEAD START APPLICATION PACKET
PROGRAM YEAR 2020-2021



Welcome to our Head Start/Early Head Start Program and 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.

Placement is based on the needs of a child and family, we are not a first come, first served program. Proof of income and an interview are required as part of the application process.

Completing the application packet is not a guarantee of placement.

WE ARE AN INCOME BASED PROGRAM AND WILL NEED YOUR 2019 INCOME:

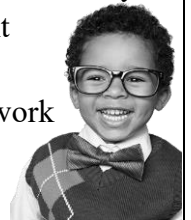
If you *currently* receive one of the following we will need verification.

Example: award letter or current statement

- SSI •W2 Cash Assistance •Foster Care Supplement •Kinship Care

If the incomes above do not apply to you, please send copies of all incomes below that apply to your family:

- 2019 Tax Return •2019 W2 Employer Statement(s) •Caretaker's Supplement
- 2019 Child Support received for all children in the home •Unemployment Compensation
- Written statement from the employer •SSDI •Written statement for cash received for work



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



**HEAD START / EARLY HEAD START
APPLICATION CHECKLIST**

	Application
	Interview
	Proof of income
	Physical
	Dental Exam (For children 3 and up)
	4K/P4J School District Paperwork <ul style="list-style-type: none"> • Beloit & Janesville only (if child is 4 on or before September 1st)

Please allow up to 30 days for processing the application. Incomplete applications will not be considered for placement. Placement for fall will begin over the summer months. Please contact us with new address/phone number changes. **We can't serve your child if we can't find you.**

If you have any questions or need help with anything please call/email us:

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APPLICATION FOR ENROLLMENT : PROGRAM YEAR 2020-2021

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

1. Child's Name: _____

DOB: _____

 Female Male**CHILD'S RACIAL/ETHNIC BACKGROUND** (Check all that apply):

<input type="checkbox"/> White	<input type="checkbox"/> American Indian / Alaska Native	Hispanic/Latino: YES NO
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Native Hawaiian/Other Pacific Islander	
<input type="checkbox"/> Asian	<input type="checkbox"/> Other:	

Child's Primary Language:	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> American Sign Language	<input type="checkbox"/> Other:
Secondary Language:	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> American Sign Language	<input type="checkbox"/> Other:
Primary Language At Home:	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> American Sign Language	<input type="checkbox"/> Other:

Child's English speaking ability? Very well Well Not well Not at allHome Address: _____
APT/LOT # CITY ZIP COUNTY

Mailing Address (if different): _____

2. CHILD LIVES PRIMARILY WITH: (Check all that apply)

<input type="checkbox"/> Both parents/Same house	<input type="checkbox"/> Mother	<input type="checkbox"/> Father
<input type="checkbox"/> Legal Step-Parent	<input type="checkbox"/> Girlfriend	<input type="checkbox"/> Boyfriend
<input type="checkbox"/> Grandparent(s)	<input type="checkbox"/> Foster Parent	<input type="checkbox"/> Legal Guardian
<input type="checkbox"/> Other:		

Is one parent away on military duty? **NO YES**Is mom pregnant? **NO YES UNSURE** If yes, when is due date:**3. WHAT IS YOUR CURRENT LIVING ARRANGEMENT** (Check one)

<input type="checkbox"/> Rent	<input type="checkbox"/> Own
<input type="checkbox"/> Relative/Friend provides a stable home	<input type="checkbox"/> Staying with family/friends short term
<input type="checkbox"/> Transitional housing	<input type="checkbox"/> Motel
<input type="checkbox"/> Shelter	<input type="checkbox"/> Mission/Church
<input type="checkbox"/> Living in car, park, campgrounds, public spaces, abandoned buildings, or poor quality housing	

4. PRIMARY PARENT / LEGAL GUARDIAN #1

NAME: _____

DOB: _____

STATUS: Single Married Divorced Separated Widowed

<input type="checkbox"/> Birth Mom	<input type="checkbox"/> Birth Dad	Race/Ethnicity: _____
<input type="checkbox"/> Legal Step-Parent	<input type="checkbox"/> Adoptive	Hispanic? YES NO
<input type="checkbox"/> Foster	<input type="checkbox"/> Guardian	Primary Language: _____
<input type="checkbox"/> Other:		

Address if different than child's family:

Primary Phone: _____ H C W	Opt in for text messages: YES NO
Secondary Phone: _____ H C W	E-Mail: _____
English speaking ability: NONE LITTLE MODERATE PROFICIENT	
Highest grade completed: _____	Did you receive? HIGH SCHOOL DIPLOMA HSED/GED NONE

5. PRIMARY PARENT / LEGAL GUARDIAN #2:

NAME: _____

DOB: _____ STATUS: Single Married Divorced Separated Widowed

Birth Mom	Birth Dad
Legal Step-Parent	Adoptive
Foster	Guardian
Other:	

Race/Ethnicity: _____

Hispanic? YES NO

Primary Language: _____

Custody: YES NO SHARED

Address if different than child's family:			
Primary Phone:	H C W	Opt in for text messages:	YES NO
Secondary Phone:	H C W	E-Mail:	
English speaking ability:	NONE LITTLE MODERATE PROFICIENT		
Highest grade completed:	Did you receive?	HIGH SCHOOL DIPLOMA HSED/GED NONE	

6. IS YOUR CHILD CURRENTLY IN?

Birth-3	Early Childhood/Special Education	WEAP
Other Home Visitation Program:		
None		
Was your child on a waitlist last year?	YES NO	If yes, what State/County?

7. DOES YOUR CHILD CURRENTLY HAVE?

IFSP
What services are they receiving? (Circle all that apply)
Speech / Language
Occupational Therapy
Other:

IEP
What services are they receiving? (Circle all that apply)
Speech / Language
Occupational Therapy
Other:

8. ARE YOU CONCERNED ABOUT ANY OF THE FOLLOWING FOR YOUR CHILD?

Physical	Health	Learning
Speech / Language	Vision	Hearing
Interacting in a group setting	Emotional	Behavioral
Other (please explain):		

9. DO YOU HAVE ANY OF THE FOLLOWING FAMILY CONCERNS?

Reading	Writing	Parent has/had an IEP
Continuing education	Transportation	Parent has a chronic illness
Mental health	Food	Shelter / Homelessness
Unemployed / Not enough hours	Alcohol / Drug use	Legal concerns
One parent is incarcerated	Both parents are incarcerated	One or both parents are deceased
Other:		

10. HOW DID YOU FIND OUT ABOUT US?

Job Center	Birth - 3	Social Media / Internet
Community Health Program/WIC	Public School Staff	Friend / Family
Health & Human Services	WEAP	Other:
Family Resource Center	Early Head Start / Head Start Staff	

11. DOES ANY MEMBER OF THE HOUSEHOLD RECEIVE THE FOLLOWING? (Check all that apply)

Food Stamps	Health Insurance (State or Private)	Caretaker supplement
W2 / Cash Assistance	Survivor's Benefits	Child Support for any child in the home
Public Housing / Section 8	Energy Assistance	None
Child Care Assistance	WIC / Healthy Start	
Other: _____		

12. LIST CHILD'S SIBLINGS CURRENTLY LIVING IN THE HOME:

	(First)	(Last)	(Relationship to child)	
1.	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female DOB: _____
2.	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female DOB: _____
3.	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female DOB: _____

Please continue on back if you need more space.

13. ADDITIONAL CONTACT PERSON(S) IN CASE WE CANNOT REACH YOU

1.	_____	_____	_____
	Name	Relationship to child	Phone
2.	_____	_____	_____
	Name	Relationship to child	Phone

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING:

Application will not be complete until we have proof of income. 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, other home visitation programs, and/or daycare providers for transportation, placement, 4K registration, and scheduling.

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.

Signature _____ Date _____

Signature _____ Date _____

INTERVIEW

<input type="checkbox"/> In-Person	<input type="checkbox"/> Phone (Reason for phone interview): _____
Staff Person: _____	Date: _____
Parent Guardian: _____	Date: _____
Proof of income obtained: _____	

FOR OFFICE USE

<input type="checkbox"/> New	<input type="checkbox"/> Transition	<input type="checkbox"/> 2 nd Year	<input type="checkbox"/> Prenatal
Transportation Form		Health History Form	
Parent/Guardian Permission for Screenings/Testing		Immunizations	
Income		Interview	
POINTS: _____	DATA ENTERED BY: _____	REVIEWED BY: _____	



CC: _____

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
Program Term 2020-2021**

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 <u>RESULTS</u> 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		

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:** _____

Signature of Parent/Guardian: _____ **Date:** _____



CC: _____

ROCK-WALWORTH COMPREHENSIVE FAMILY SERVICES INC.
HEAD START AND EARLY HEAD START® • *Serving Rock & Walworth Counties*

Health / Nutritional History

Child's Name: _____ Date of Birth: _____

Child's Doctor: _____ Clinic Name/Phone: _____

Child's last Well Child Check: _____ (We will need a copy if your child is enrolled)

Child's Dentist: _____ Clinic Name/Phone: _____

Child's last Dental Exam: _____ (We will need a copy if your child is enrolled)

Insurance Coverage: Private Badger Care/Medicaid None Other _____

Does your child have or did he/she have?	Yes		No	Medication		Explanation (as needed)
	Now	Past		Yes	No	
Asthma						
Seizures						
Heart Issues						
Diabetes						
High Lead Level						
Sickle Cell Disease						
Anemia						
Vision Concerns						Glasses? Yes No
Hearing Concerns						Hearing Aids? Yes No Tubes? Yes No
Any Other Health Concerns?						

Will any medication need to be given while here? Yes No
If yes, please list:

Has your child ever had surgery? Yes No **Been in the hospital?** Yes No
If yes, please explain:

Does your child have any allergies to food? Yes No **Other Allergies?** Yes No
If yes, please list:

How does he/she react?

Does your child have any other food restrictions? Yes No
If yes, to what and why:

Was your child born more than 2 weeks early? Yes No **If yes, how early?**

Were there any concerns with the pregnancy or birth? Yes No **If yes, explain:**

Do you or your child's doctor have a concern about your child's development? Yes No
If yes, please explain:

Is your child potty trained? Yes No **Concerns?**

Will he/she need to use diapers/pull ups at school? Yes No **If yes, what size?**

Has your child seen a dentist? Yes No	Does your child drink fluoridated water? Yes No
Has your child ever had a cavity? Yes No	Does your child complain of mouth pain? Yes No
How many times a day does your child brush? _____	Does he/she get help brushing? Yes No
Does anyone in the household smoke (includes cigarettes, electronic cigarettes, Juul, etc.)? Yes No	

If yes, would you like information on how and why to quit?	Yes	No
Would you be interested in a class/support group for people trying to quit?	Yes	No

Nutrition Questions	
Foods your child really likes?	
Foods your child doesn't like?	
How does your child feel about meal time?	<input type="checkbox"/> Enjoys <input type="checkbox"/> Not Interested <input type="checkbox"/> Needs Encouragement
How is your child's appetite?	<input type="checkbox"/> Good <input type="checkbox"/> Average <input type="checkbox"/> Picky <input type="checkbox"/> Poor
Do you have concerns about what your child is eating?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Please explain:
Do you have concerns about your child's weight?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Please explain:
Any problems with:	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Vomiting <input type="checkbox"/> Other If anything marked, please explain:
Do you have any questions or concerns about your child's nutrition that we can help with?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:
Do you participate in WIC?	<input type="checkbox"/> Yes <input type="checkbox"/> No Would you like information on the WIC program? <input type="checkbox"/> Yes <input type="checkbox"/> No

Does your child:	Yes	No	Comment
Eat solid food			
Drink from a cup			
Feed self			
Take a bottle			
Eat or chew things that aren't food			
Have trouble swallowing or chewing			
Have more than 1 sugary item a day			
Exercise at least 1 hour every day			
Have more than 2 hours screen time			

For Babies under 12 months:			
	Yes	No	Comment
Does your baby get breast milk?			
Does your baby get formula?			Type?
How often does your child eat/get fed?	Every _____ hours		
Any food introduced? Please list:			

By signing below, I understand that I am responsible for providing any needed medical, dental, and nutritional records RWCFS requests in order to ensure my child is safe and has his/her unique needs met while in their care. I understand my child may not be able to attend in a classroom until appropriate documentation from a licensed medical provider is given, a plan is completed for care, and/or staff receive needed training. With my signed consent, I understand that RWCFS can support me in getting required records.

Parent/Guardian Signature Date

2nd Year - Parent/Guardian Recertification Date Reviewed