Rock/Walworth Comprehensive Family Services, INC.
Head Start/Early Head Start Application Packet
Program Year 2021-2022

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 2020 INCOME:

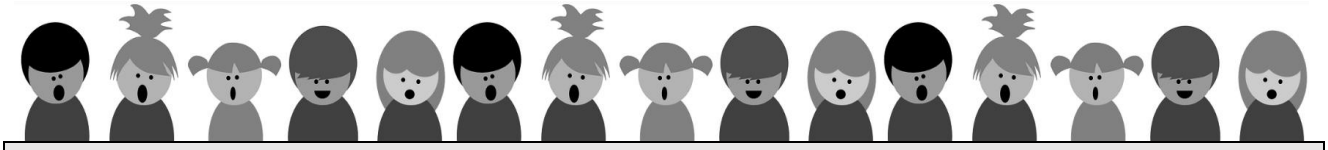
If you *currently* receive one of the following we will need verification.
Example: award letter or current statement

•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:

• 2020 Tax Return •2020 W2 Employer Statement(s) •Caretaker's Supplement
•2020 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.



	APPLICATION CHECKLIST
	Application
	Interview
	Proof of income
	Physical
	Dental Exam (For children 3 and up)
	4K/P4J School District Paperwork • 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:

Janice Kuchelmeister
jkuchelmeister@cfsheadstart.org

Maria Olvera
molvera@cfsheadstart.org

Nancy Marx
nmarx@cfsheadstart.org

CC: _____

APPLICATION FOR ENROLLMENT : PROGRAM YEAR 2021-2022
THIS APPLICATION SHOULD ONLY BE FILLED OUT AND SIGNED BY THE LEGAL PARENT/GUARDIAN(S)

1. Child's Name: _____
FIRST MIDDLE LAST

DOB: _____ ☐Female ☐Male

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

☐ White ☐ American Indian/Alaska Native
☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander
☐ Asian ☐ Other:

Hispanic?
☐ Yes ☐ No

Child's Primary Language: ☐ English ☐ Spanish ☐ American Sign Language ☐ Other:

Child's 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

Home Address: _____
APT/LOT # CITY ZIP COUNTY

Mailing Address (if different): _____

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

☐ Both Parents / Same Home ☐ Mother ☐ Father ☐ Legal Step-Parent
☐ Girlfriend ☐ Boyfriend ☐ Grandparent(s) ☐ Foster Parent
☐ Legal Guardian ☐ Other: _____

Is one parent away on military duty? ☐ Yes ☐ No **Is mom pregnant?** ☐ Yes ☐ No

2. WHAT IS YOUR CURRENT LIVING ARRANGEMENT

☐ Rent ☐ Own ☐ Staying with family/friends long term ☐ Foster Home ☐ Other:

☐ I am homeless. This means that you are staying in a car, park, campgrounds, hotel, emergency shelter, transitional housing, on the street, or are living with family/friends short term. *If homeless, please check which applies to you:*

☐ Motel/Hotel ☐ Shelter ☐ Mission/Church ☐ Transitional Housing ☐ Staying on the street ☐ Family/Friends short term

3. PRIMARY PARENT / LEGAL GUARDIAN #1

NAME: _____

DOB: _____ **STATUS:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

☐ Birth Mom ☐ Birth Dad ☐ Legal Step-Parent ☐ Adoptive ☐ Foster ☐ Guardian
☐ Other: Primary Language: _____

Race/Ethnicity: _____ Hispanic? ☐ Yes ☐ No

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

Completed Elementary School: ☐ Yes ☐ No Did you receive? ☐ High School Diploma ☐ HSED/GED ☐ None

4. PRIMARY PARENT / LEGAL GUARDIAN #2

NAME: _____

DOB: _____ **STATUS:** ☐ Single ☐ Married ☐ Divorced ☐ Separated

☐ Birth Mom ☐ Birth Dad ☐ Legal Step-Parent ☐ Adoptive ☐ Foster ☐ Guardian

☐ Other: Custody? ☐ Yes ☐ No ☐ Shared

Race/Ethnicity: _____ Hispanic? ☐ Yes ☐ No

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

Completed Elementary School: ☐ Yes ☐ No Did you receive? ☐ High School Diploma ☐ HSED/GED ☐ None

6. IS YOUR CHILD CURRENTLY IN?

☐ Birth-3 ☐ Early Childhood/Special Education ☐ Autism Services (WEAP, Caravel, etc.) ☐ Early Head Start

☐ 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?

☐ No

☐ IFSP

What services are they receiving? (check all that apply)

☐ Speech / Language ☐ Early Childhood

☐ Occupational Therapy ☐ Physical Therapy

☐ Other:

☐ IEP

What services are they receiving? (check all that apply)

☐ Speech / Language ☐ Early Intervention

☐ Occupational Therapy ☐ Physical Therapy

☐Other:

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

☐ Learning ☐ Physical ☐ Health ☐ Vision ☐ Behavioral

☐ Hearing ☐ Speech / Language ☐ Interacting in a group setting ☐ Emotional ☐ ***None***

☐ Other:

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 ☐ Not enough food in the home ☐ 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:

☐ ***None***

10. HOW DID YOU FIND OUT ABOUT US?

☐ Day Care	☐ Birth-3	☐ School Staff
☐ Early Head Start/Head Start Staff	☐ Job Center: Rock/Walworth Co	☐ Doctor
☐ Social media / Internet	☐ Counselor	☐ Children's WI Resource Center
☐ Friend/Family	☐ Community Health Program/WIC	☐ Autism Services Provider
☐ ***Other:***	☐ Health & Human Services	☐ Homeless/Domestic Violence Shelter

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

☐ Foster / Kinship Care	☐ Health Insurance (State or private)	☐ Food Stamps
☐ Supplemental Security Income (SSI)	☐ Caretaker Supplement	☐ SSI - Social Security
☐ W2 / Cash Assistance	☐ Survivor's Benefits	☐ Child Care Assistance
☐ Other:	☐ Public Housing / Section 8	☐ WIC / Healthy Start
☐ ***None***	☐ Energy Assistance	☐ Child Support for **any** child in the home

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

1. _____
Name Relationship to child Phone

2. _____
Name Relationship to child Phone

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

(First) (Last) (Relationship to child)

1. _____ ☐ Male ☐ Female DOB: _____

2. _____ ☐ Male ☐ Female DOB: _____

3. _____ ☐ Male ☐ Female DOB: _____

Please continue on back if you need more space.

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.

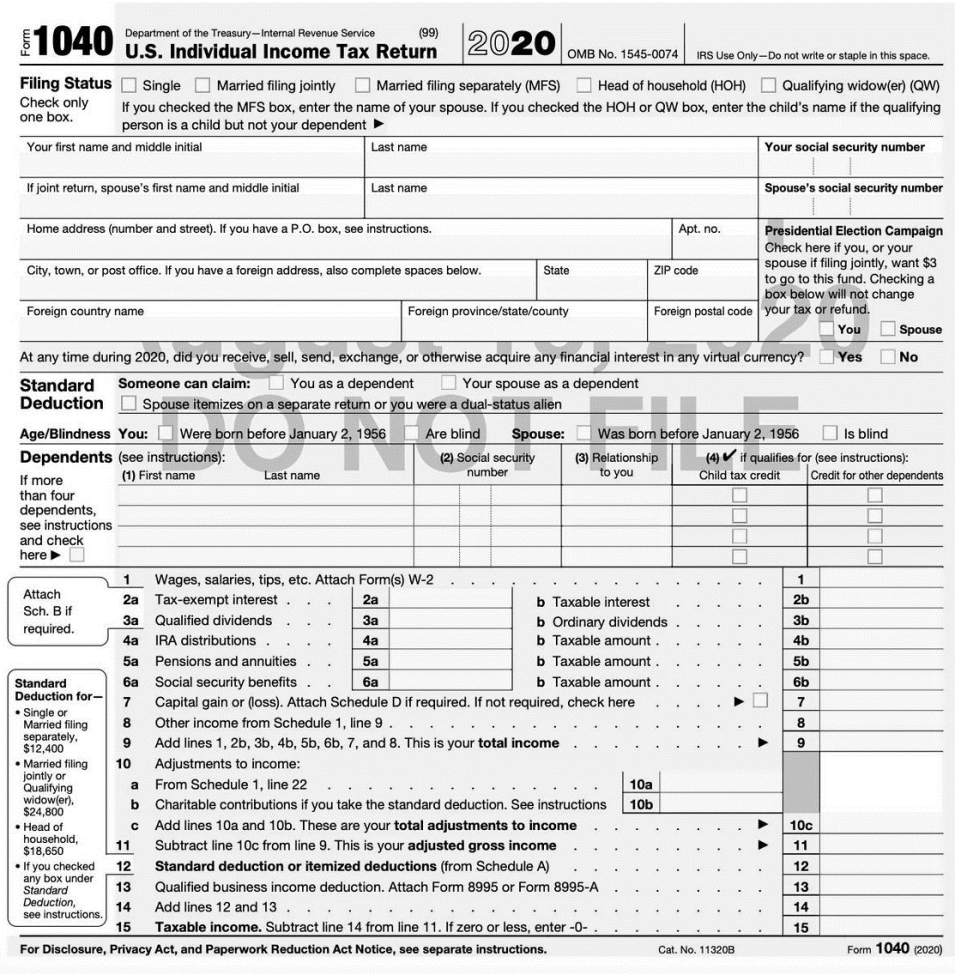
Signature_____ Date_____

Signature_____ Date_____

INTERVIEW			
	In-Person		Phone (Reason for phone interview):
Staff Person:			Date:
Parent Guardian:			Date:
Proof of income obtained:			

FOR OFFICE USE							
	New		Transition		2nd Year		3rd Year
	Transportation Form				Health History Form		
	Parent/Guardian Permission for Screenings/Testing				Immunizations		
	Income						
INCOME POINTS		**TOTAL POINTS:**		**DATA ENTERED BY:**		**REVIEWED BY:**	

Example of Income Tax Return form that we need to collect as proof of income:



Form **1040** Department of the Treasury—Internal Revenue Service (99) **U.S. Individual Income Tax Return** **2020** OMB No. 1545-0074 IRS Use Only—Do not write or staple in this space.

Filing Status Check only one box. ☐ Single ☐ Married filing jointly ☐ Married filing separately (MFS) ☐ Head of household (HOH) ☐ Qualifying widow(er) (QW)
If you checked the MFS box, enter the name of your spouse. If you checked the HOH or QW box, enter the child's name if the qualifying person is a child but not your dependent ▶

Your first name and middle initial	Last name	Your social security number
If joint return, spouse's first name and middle initial	Last name	Spouse's social security number

Home address (number and street). If you have a P.O. box, see instructions. | Apt. no.

City, town, or post office. If you have a foreign address, also complete spaces below. | State | ZIP code

Foreign country name | Foreign province/state/county | Foreign postal code

Presidential Election Campaign Check here if you, or your spouse if filing jointly, want $3 to go to this fund. Checking a box below will not change your tax or refund. ☐ You ☐ Spouse

At any time during 2020, did you receive, sell, send, exchange, or otherwise acquire any financial interest in any virtual currency? ☐ Yes ☐ No

Standard Deduction **Someone can claim:** ☐ You as a dependent ☐ Your spouse as a dependent
☐ Spouse itemizes on a separate return or you were a dual-status alien

Age/Blindness **You:** ☐ Were born before January 2, 1956 ☐ Are blind **Spouse:** ☐ Was born before January 2, 1956 ☐ Is blind

Dependents (see instructions): If more than four dependents, see instructions and check here ▶ ☐

(1) First name Last name	(2) Social security number	(3) Relationship to you	(4) ✓ if qualifies for (see instructions): Child tax credit	Credit for other dependents
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Attach Sch. B if required.

1	Wages, salaries, tips, etc. Attach Form(s) W-2			1	
2a	Tax-exempt interest	2a	b Taxable interest	2b	
3a	Qualified dividends	3a	b Ordinary dividends	3b	
4a	IRA distributions	4a	b Taxable amount	4b	
5a	Pensions and annuities	5a	b Taxable amount	5b	
6a	Social security benefits	6a	b Taxable amount	6b	
7	Capital gain or (loss). Attach Schedule D if required. If not required, check here ▶ ☐			7	
8	Other income from Schedule 1, line 9			8	
9	Add lines 1, 2b, 3b, 4b, 5b, 6b, 7, and 8. This is your **total income** ▶			9	
10	Adjustments to income:				
a	From Schedule 1, line 22	10a			
b	Charitable contributions if you take the standard deduction. See instructions	10b			
c	Add lines 10a and 10b. These are your **total adjustments to income** ▶			10c	
11	Subtract line 10c from line 9. This is your **adjusted gross income** ▶			11	
12	**Standard deduction or itemized deductions** (from Schedule A)			12	
13	Qualified business income deduction. Attach Form 8995 or Form 8995-A			13	
14	Add lines 12 and 13			14	
15	**Taxable income.** Subtract line 14 from line 11. If zero or less, enter -0-			15	

Standard Deduction for—
- Single or Married filing separately, $12,400
- Married filing jointly or Qualifying widow(er), $24,800
- Head of household, $18,650
- If you checked any box under *Standard Deduction*, see instructions.

For Disclosure, Privacy Act, and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 11320B Form **1040** (2020)

Additional Space for siblings living in home

(First) (Last) (Relationship to child)

4._____ ☐ Male ☐ Female DOB: _____

5. _____ ☐ Male ☐ Female DOB: _____

6. _____ ☐ Male ☐ Female DOB: _____

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 2021-2022

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		

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? □ Enjoys □ Not Interested □ Needs Encouragement			
How is your child's appetite? □ Good □ Average □ Picky □ Poor			
Do you have concerns about what your child is eating? □ Yes □ No **If yes, Please explain:**			
Do you have concerns about your child's weight? □ Yes □ No **If yes, Please explain:**			
Any problems with: □ Diarrhea □ Constipation □ Vomiting □ Other **If anything marked, please explain:**			
Do you have any questions or concerns about your child's nutrition that we can help with? □ Yes □ No **If yes, please explain:**			
Do you participate in WIC? □ Yes □ No	**Would you like information on the WIC program?** □ Yes □ 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