Wounspe Oaye Tokahe
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Student Application 2017-2018

What is Head Start/Early Head Start?

Head Start and Early Head Start are comprehensive child development programs which serve children from birth to age 5, pregnant women, and their families. They are child-focused programs, and have the overall goal of increasing the social competence of young children in either low-income and homeless families or both. By "social competence" is meant the child's everyday effectiveness in dealing with either his or her present environment and later responsibilities in school and life. Social competence takes into account the interrelatedness of social, emotional, cognitive, and physical development.

What is Oglala Lakota College Head Start Program?

Our goal is to provide a full range of services to meet the needs of Lakota children from prenatal-5 and their families addressing cognitive, emotional, physical, nutritional, mental health, and Lakota language and culture development of the children and the development needs of families.

How to apply for Head Start/Early Head Start?

Please read this eligibility application carefully and fill it out completely. It contains important information that is used to determine if your child is eligible for Head Start/Early Head Start services based on the federal requirements and the OLC selection criteria is located on page 4 of the attached eligibility application.

Who is age eligible to participate in the pre-school head start services (3-5 year olds)?

To be eligible for Head Start services, a child must be at least three years old by the date used to determine eligibility for public school in the community in which the Head Start program is located, except in cases where the Head Start program's approved grant provides specific authority to serve younger children. Examples of such exceptions are programs serving children of migrant families and Early Head Start programs.

What Happens Next?

When we receive your eligibility application, it will be reviewed and you will be contacted if we need more information or if your family does not qualify for services. Once your family has been determined eligible you will receive additional documents to fill out to complete the registration process.

Checklist

These documents must be submitted with the attached eligibility application.

☐ Completed Eligibility Application (required for determining eligibility)
☐ Family's Proof of Income (required for determining eligibility)
☐ Immunization Record *(current for age as required by SD school immunization law 13-28-7.1)*
☐ Copy of Medical Insurance
☐ Guardianship/Custody Papers(if applicable)
☐ IFSP/IEP Documentation (if applicable)

Wounspe Oaye Tokahe
Head Start/Early Head Start Program

Date Intake/Application Completed: _____
(Office Use Only)

Eligibility Application

Center Applying for: _____

ELIGIBLE CHILD DEMOGRAPHICS:

First: _____ Middle: _____ Legal Last Name: _____

DOB: _____ /_____ /_____ SSN: _____-_____-_____ Race: _____ Ethnicity: _____

Gender (Circle): Male / Female Language (Check): English (☐ 1st) / (☐ 2nd) Lakota (☐ 1st) / (☐ 2nd) Spanish (☐ 1st) / (☐ 2nd) ☐ Other

FAMILY MEMBERS DEMOGRAPHICS:

#1 Parent/Guardian – First: _____ Middle Initial: _____ Last Name: _____

DOB: _____ /_____ /_____ Race: _____ Marital Status (Circle): Single / Separated / Married / Divorced

Gender (Circle): Male / Female Language (Check): English (☐ 1st) / (☐ 2nd) Lakota (☐ 1st) / (☐ 2nd) Spanish (☐ 1st) / (☐ 2nd) ☐ Other

Living Address: _____ Mailing Address: _____

City: _____State: _____ Zip Code: _____ Mobile Phone: _____

#1 Home Phone: _____ #2 Home Phone: _____ Work Phone: _____

Role in Household (Circle One Below):
1. Mother/Mother Figure 3. No Longer a Family Member
2. Father/Father Figure 4. Family Member Residing at Different Address

Relationship Details (Circle One Below):
1. Emergency Contact 3. Authorized to Receive Child
2. No Contact Allowed
***If no contact, please provide documentation

Occupation (Check One Below):
☐ Employed Full-time/In-school Part-time ☐ School Full-time ☐ Unemployed ☐ N/A Occupation Start Date: _____ /_____ /_____
☐ In-school Full-time/Employed Part-time ☐ Employed ☐ Other ☐ In Job Training Program

Education (Circle Appropriate Below):
1. Elementary (Circle One) - (4th) / (5th) / (6th) / (7th) / (8th) 2. High School (Circle) - (9th) / (10th) / (11th) / (12th No Diploma) 3. Other 4. CDA
5. High School Diploma or Equivalent 6. Degree (Circle One) - (AA) / (BS) / (MA) / (PHD) / (Some College – No Diploma)

Education Start Date: _____ /_____ /_____

Applicant currently pregnant? (Circle One): Yes / No Due Date: _____ /_____ /_____

#2 Parent/Guardian – First: _____ Middle Initial: _____ Last Name: _____

DOB: _____ /_____ /_____ Race: _____ Marital Status (Circle): Single / Separated / Married / Divorced

Gender (Circle): Male / Female Language (Check): English (☐ 1st) / (☐ 2nd) Lakota (☐ 1st) / (☐ 2nd) Spanish (☐ 1st) / (☐ 2nd) ☐ Other

Living Address: _____ Mailing Address: _____

City: _____State: _____ Zip Code: _____ Mobile Phone: _____

#1 Home Phone: _____ #2 Home Phone: _____ Work Phone: _____

Role in Household (Circle One Below):
1. Mother/Mother Figure 3. No Longer a Family Member
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Relationship Details (Circle One Below):
1. Emergency Contact 3. Authorized to Receive Child
2. No Contact Allowed
***If no contact, please provide documentation

Occupation (Check One Below):
☐ Employed Full-time/In-school Part-time ☐ School Full-time ☐ Unemployed ☐ N/A Occupation Start Date: _____ /_____ /_____
☐ In-school Full-time/Employed Part-time ☐ Employed ☐ Other ☐ In Job Training Program

Education (Circle Appropriate Below):
1. Elementary (Circle One) - (4th) / (5th) / (6th) / (7th) / (8th) 2. High School (Circle) - (9th) / (10th) / (11th) / (12th No Diploma) 3. Other 4. CDA
5. High School Diploma or Equivalent 6. Degree (Circle One) - (AA) / (BS) / (MA) / (PHD) / (Some College – No Diploma)

Education Start Date: _____ /_____ /_____

Applicant currently pregnant? (Circle One): Yes / No Due Date: _____ /_____ /_____

CHILD INFORMATION:

Concerns about child's overall health and development (Circle One): Yes / No Describe concerns: _____

Concerns expressed by (Check One): ☐ EHS Staff / ☐ HS Staff / ☐ Family Member / ☐ Medical Provider / ☐ Other Person or Agency

Child to be care for by someone other than the Head of Household (Check Appropriate Boxes Below):

☐ Adult relative in child's own home ☐ Relative ☐ Public School Pre-K program

☐ Older sibling age 12 or older ☐ Unrelated adult in child's own home ☐ Child Care Center

FAMILY INFORMATION:

Head of Household (Circle One Below):

1. #1 Parent/Guardian
2. #2 Parent/Guardian

Family Type (Circle One Below):

1. Foster Parent
2. Two Parent Family
3. Single Parent (Mother Figure Only)
4. Single Parent (Father Figure Only)

Family Housing Type (Check One Below):

☐ Apartment ☐ Community Shelter ☐ House ☐ Other

☐ BIA School Housing ☐ Mobile Home/Trailer ☐ OSLA Housing

Housing Payment Type (Check One Box): ☐ Own Housing / ☐ Rent Housing / ☐ Make No Payment for Housing / ☐ Other

Length of Time at Current Address (Check One Box): ☐ 1-2 Years / ☐ 6-12 Months / ☐ Less than 6 Months / ☐ More Than 2 Years

During the enrollment year was the Family homeless? (Circle): Yes / No Family Acquired Housing During Enrollment Year (Circle): Yes / No

Family Currently has Means of Transportation (Circle): Yes / No

Transportation Used (Circle One Below):

1. Private Vehicle (car,truck,van) – (Primary) / (Secondary)
2. Parent Transport – (Primary) / (Secondary)
3. Friend's or Relative's Vehicle – (Primary) / (Secondary)
4. School Bus – (Primary) / (Secondary)
5. Other – (Primary) / (Secondary)

# of Adults in Family (Circle)? - (1) / (2) / (3) / (4) / (5) / (5+)

# of Adults Contributing to the Income (Circle)? - (1) / (2) / (2+)

# of Children in Family (Circle)? - (1) / (2) / (3) / (4) / (5) / (5+)

Referral Source (Check One Below):

☐ Child Welfare Agency ☐ Hospital/Health Clinic ☐ Self Referral

☐ Friends/Family ☐ Outreach/Recruitment

INVOLVED ADULTS / EMERGENCY CONTACTS:

#1 Adult – First: _____ Middle Initial: _____ Last Name: _____

DOB: _____ /_____ /_____ Race: _____ Gender (Circle): Male / Female

Language (Check): English (☐ 1st) / (☐ 2nd) Lakota (☐ 1st) / (☐ 2nd) Spanish (☐ 1st) / (☐ 2nd) ☐ Other

Living Address: _____ Mailing Address: _____

City: _____State: _____ Zip Code: _____ Mobile Phone: _____

#1 Home Phone: _____ #2 Home Phone: _____ Work Phone: _____

#2 Adult – First: _____ Middle Initial: _____ Last Name: _____

DOB: _____ /_____ /_____ Race: _____ Gender (Circle): Male / Female

Language (Check): English (☐ 1st) / (☐ 2nd) Lakota (☐ 1st) / (☐ 2nd) Spanish (☐ 1st) / (☐ 2nd) ☐ Other

Living Address: _____ Mailing Address: _____

City: _____State: _____ Zip Code: _____ Mobile Phone: _____

#1 Home Phone: _____ #2 Home Phone: _____ Work Phone: _____

#3 Adult – First: _____ Middle Initial: _____ Last Name: _____

DOB: _____ /_____ /_____ Race: _____ Gender (Circle): Male / Female

Language (Check): English (☐ 1st) / (☐ 2nd) Lakota (☐ 1st) / (☐ 2nd) Spanish (☐ 1st) / (☐ 2nd) ☐ Other

Living Address: _____ Mailing Address: _____

City: _____State: _____ Zip Code: _____ Mobile Phone: _____

#1 Home Phone: _____ #2 Home Phone: _____ Work Phone: _____

ABOUT YOUR INCOME:

This is required information: Please fill out completely and attach copies (not originals) *of forms that provide proof of your income. Proof of income can be presented through W-2 forms, Individual Tax Form 1040, pay stub/pay envelopes, current public assistance receipt (*notice of Action forms*) Written employers statement, Social Security, and/or forms that verify income from other sources (*child support, etc*).*

Types of Services or Financial Assistance Received (Check All Boxes Below That Apply):

☐ Supplemental Security Income (SSI) ☐ Foster Care/Adoption Subsidy ☐ WIC

☐ Medical Financial Assistance (i.e., Medicaid/Medicare) ☐ Child Support/Alimony ☐ No Services Received

☐ Supplemental Nutrition Assistance Program (SNAP) aka Food Stamps

Are you currently receiving service through TANF, or have you in the past year? (Circle): Yes / No

Are you currently a foster parent of the child wishing to enroll in Head Start/Early Head Start? (Circle): Yes / No

Are you currently receiving SSI or have been in the past year? (Circle): Yes / No

1. I declare under penalty of perjury that the information provided is true and correct to the best of my knowledge.
2. I will notify the agency immediately if there is any change in my income, family size, residence, employment, or reason for needing child development services.
3. I understand that the information about my eligibility may be reviewed by representatives of the State of South Dakota, The Federal Government, independent auditors, or others as necessary for the administration of the program.
4. I understand that I will receive a notice of approval or disapproval of my eligibility application.
5. I understand that this certification is not complete until all documentation is submitted and this form has been reviewed, signed, dated by an agency representative and signed and dated by me.
6. I understand there is additional paperwork for me to fill out if my child is approved for Head Start/Early Head Start.

_____ _____ /_____ /_____

Parent/Guardian Signature Date

CACFP Enrollment Form

Please complete and/or update and sign this form and return it to _____ no later than _____.

Our agency participates in the Child and Adult Care Food Program (CACFP) and receives Federal reimbursement for the meals served to your child(ren). The Federal regulations for the CACFP require us to collect and update this information on an annual basis for all of our enrolled children. This information is used to confirm your child(ren)'s current enrollment in the center and thus in the CACFP. All information is confidential and will be shared with appropriate personnel and state/federal staff as needed. **Note**: The indication of racial and ethnic background is optional and will not affect eligibility for the Program. This information is used for reporting purposes only. By providing this information you will assist us in assuring that this program is administered in a nondiscriminatory manner. If racial / ethnic background is not reported, a visual identification of the child's race and ethnicity will be made.

(Select one or more)

Full Name(s) of Enrolled Child(ren)	*** Race/ Ethnicity**	**Date of Birth**	**Normal Hours In Care**		
			____ to ____	M T W T F	B L PM
			____ to ____	M T W T F	B L PM
			____ to ____	M T W T F	B L PM
			____ to ____	M T W T F	B L PM
			____ to ____	M T W T F	B L PM

* **Race:** Hispanic or Latino **Ethnicity:** American Indian or Alaskan Native / Asian / Black or African American / Native Hawaiian or other Pacific Islander / White

** B = Breakfast L = Lunch PM = PM Snack

Special needs or instructions (i.e. allergies): _____

Parent/Guardian's Name: _____ Phone Number: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Mother's Employer: _____ Phone Number: _____

Father's Employer: _____ Phone Number: _____

Family Doctor: _____ In Emergency Call: _____

Parent Signature: _____ Date: _____

"In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating 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, S.W., Washington, D.C. 20250-9410, or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer."

Office use Only: Enrollment Date: _____ Update Date: _____ Dismissal Date: _____