COMMUNITY SERVICES OFFICE

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Email: headstartdirector@csoarkansas.org

2022 - 2023 Application

Head Start / Early Head Start / Early Head Start Child Care Partnerships

Mission Statement

Empower economically disadvantaged people to achieve self-sufficiency through advocacy, education, and employment.

If you need any assistance completing this application, please contact us.
We will gladly help you.

*****AN INCOMPLETE APPLICATION MAY DELAY YOUR CHILD'S ENROLLMENT*****

Enrollment Process

The enrollment process of your child is not complete without all the information listed below:

_____ Application - Completed, signed, printed name, and dated
_____ Immunization or Shot record
_____ Dental Screening
_____ Child's Medicaid or insurance card (if applicable)
_____ Birth Certificate (or other official verification of child's age)
_____ Family proof of income: (one of the following) Income Tax, W-2, Check Stubs, Verification from Employer, Self-Employment-1040 schedule C, Unemployment Benefits/Workers Compensation, SS or SSI, VA Benefits/Pensions, Retirement Income, Tea/Work Pays, Royalties, Work Study Income, Child Support Proof, Contributions, Statement, etc.
_____ Physical with the Lead & Hematocrit or Hemoglobin level listed
_____ Certified IEP (For those with suspected or diagnosed disabilities)
_____ Doctor's Documentation of any diagnosed medical conditions such as, but not limited to; Asthma, Diabetes, Sickle Cell Anemia, etc., and any prescribed medications that would need to be administered during school hours.
_____ Photo ID, Driver's License, State ID, Federal ID, or Student ID, etc.

Early Head Start Child Care Partnership (EHSCCP) (age birth through 2) also requires the following:

_____ Proof of Residence: (Utility Bill, State or Federal ID, Completed Current Lease Agreement, or Current Mortgage Payment that lists the address)
_____ Child's Social Security Card
_____ Proof of Alien status for any household member who is not a U.S. Citizen
_____ DHS Voucher Application Parent Letter
_____ Parent's Class Schedule (If Applicable)

Office Use Only
Circle One:

HS / EHS

1st Year

2nd Year

This Institution is an Equal Opportunity Provider

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at http://www.ascr.usda.gov/complaint_filing_cust.html and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: Mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; Fax: (833) 256-1665 | (202) 690-7442; or Email: program.intake@usda.gov

Eligibility – Children from birth to 5 are eligible for Head Start or Early Head Start. There is no cost to attend the Head Start/Early Head Start Program; however, transportation is not provided. The following are categorically eligible:

- Children with family incomes below the Federal Poverty Level
- Children of families eligible for Temporary Assistance for Needy Families (TANF)
- Children of families eligible for Supplemental Security Income (SSI)
- Children who are experiencing Homelessness
- Children in the Child Welfare System (Foster Care)

Recruitment – Head Start/Early Head Start families are recruited in the County. Advertisements and applications are made available at various locations and can also be obtained by contacting CSO. When parents or guardians wish to enroll their children, they complete an application.

Selection – Upon receipt of an application, it is first checked for completion. If it is complete, the ERSEA Coordinator screens the application for eligibility using a point system, which is based on the needs of the family. After review, all eligible applicants are either enrolled or placed on a waiting list and their parent/guardian is notified by letter or phone concerning the status of their application.

Enrollment – Applicants are placed on the waiting list in order of need and are enrolled when a slot becomes available. Upon enrollment, an appointment time is set for the family to complete the Orientation. During Orientation, they complete more paper work and speak to the content staff. Early Head Start students must requalify to attend Head Start.

Attendance – Head Start children are expected to come to class on the first day of school or upon enrollment and Early Head Start children upon enrollment.

Criteria for Selection

- Head Start/Early Head Start will place families that are at or under the income guideline (100% or below) as soon as slots become available using a point system by which the families with the most points are placed first.
- Eligible families that are between 100% and 130% on the income guideline will be placed second (35% of slots may be in this category)
- If slots are still available, eligible families who are over 130% will be added last (10% of slots may be in this category)
- In the event that several families have the same number of points, the family who applied first will be placed first.
- At least 10% of our slots will be used for children with disabilities.

Note: In order for you to receive notification, it is important that we maintain a current address and phone number for your family. Therefore, please notify us if any changes are made.

Child's Personal Data

Date Applied ____/____/_____ School District in which the child currently resides _____

Desired Center/Classroom – 1st Choice _____ 2nd Choice _____

Child's Information:

Child's Name _____ _____ _____
First Middle Last

Age as of August 1, this year _____ Date of birth: _____/_____/_____ SSN #: _____-_____-_____

Language(s) spoken: English____, Spanish____, Other: _____ Gender: Male ____ Female____

Race: (Circle one or any that apply to you)

White Black / African American Hispanic / Latino

American Indian Pacific Islander / Native Hawaiian Bi-racial

Asian Other_____

Medicaid #_____

(AR Kids ___ AR kids First ___, A ___, B ___, # _____)

Private Insurance # _____ ID/policy # _____

Military Health (Tri-Care or CHAMPUS) _____

Non-Insured at this time of enrollment _____

Did Head Start/ Early Head Start assist you in filling out an application for AR Kids Insurance? Yes____ No____

Signature:

Please read & sign:

I, _____, (Legal Guardian) do hereby give my consent to the Director of Community Services Office Head Start/Early Head Start, or his/her duly appointed representative, for said child, _____, to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parent/guardian cannot be reached. Consent is also given for the Director or his duly appointed representative to transport said child for emergency medical treatment if the parent cannot be reached. I, the parent/guardian of this child, understand that I may ask for a conference with the caregiver(s) as needed.

Signed _____ Date ____/____/_____

Witness _____ Date ____/____/_____

First Parent/Guardian's Information:

Which one are you? Parent _____ Stepparent _____ Grandparent _____ Foster Parent _____ Other _____
Check one: Single _____ Married _____ Widowed _____ Divorced _____ Separated _____
Unmarried Living Together _____ Other _____
Incarcerated: Yes _____ No _____ In Drug or Alcohol Rehab: Yes _____ No _____
Is child living with relatives/friends due to parent incarceration or abandonment? Yes _____ No _____
Is mother living with enrolling child's father? Yes _____ No _____
Name of person enrolling child _____ Relationship to child _____
If not the child's biological parent, specify your relationship to the child. _____
Who is legally responsible for child? Parent/Guardian 1 _____ Parent/Guardian 2 _____ Both Parents _____
Foster Care _____ Grandparent(s) _____ Other _____
In Military Services Yes _____ No _____ Is parent currently deployed Yes _____ No _____

Name_____ DOB _____/_____/_____ Age _____ Race _____
Gender _____ Primary Language _____ English Proficiency _____
Parent's place of employment _____ Department _____
Work Hours: from _____ to_____ Employed full time? Yes ____ No _____ Part time? Yes _____ No _____
Retired? Yes _____ No _____ Veteran? Yes _____ No _____ Disabled? Yes _____ No _____
Highest-grade completed _____ Did you graduate? Yes ___ No ___ Date graduated _____ GED? Yes ___ No ___

Living Address: _____ Move in date _____ Apt. # _____ City _____
County _____ State _____ Zip _____
Is your current address a temporary living arrangement? Yes _____ No _____
Mailing Address: _____ Apt. # _____ City _____ State ____ Zip _____
Home Phone # _____-_____-_____ Cell Phone # _____-_____-_____
Work Phone # _____-_____-_____ Message Phone # _____-_____-_____
Parent in School/Training: Yes _____ No _____ Student Status: Full Time _____ Part Time _____
School's Name _____ Course of Study _____
Do you have a Degree or Certificate? Yes _____ No _____ Date Degree or Certificate achieved _____
In what field? _____
Email Address: _____
Are you pregnant? Yes _____ No _____ Expected Due Date: _____/_____/_____

Second Parent/Guardian's Information:

Which one are you? Parent _____ Stepparent _____ Grandparent _____ Foster Parent _____ Other _____
Check one: Single _____ Married _____ Widowed _____ Divorced _____ Separated _____
Unmarried Living Together _____ Other _____
Incarcerated: Yes _____ No _____ In Drug or Alcohol Rehab: Yes _____ No _____
Is child living with relatives/friends due to parent incarceration or abandonment? Yes _____ No _____
Is mother living with enrolling child's father? Yes _____ No _____
Name of person enrolling child _____ Relationship to child _____
If not the child's biological parent, specify your relationship to the child. _____
Who is legally responsible for child? Parent/Guardian 1 _____ Parent/Guardian 2 _____ Both Parents _____
Foster Care _____ Grandparent(s) _____ Other _____
In Military Services Yes _____ No _____ Is parent currently deployed Yes _____ No _____

Name_____ DOB _____/_____/_____ Age _____ Race _____
Gender _____ Primary Language _____ English Proficiency _____
Parent's place of employment _____ Department _____
Work Hours: from _____ to_____ Employed full time? Yes ____ No _____ Part time? Yes _____ No _____
Retired? Yes _____ No _____ Veteran? Yes _____ No _____ Disabled? Yes _____ No _____
Highest-grade completed _____ Did you graduate? Yes ___ No ___ Date graduated _____ GED? Yes ___ No ___

Living Address: _____ Move in date _____ Apt. # _____ City _____
County _____ State _____ Zip _____
Is your current address a temporary living arrangement? Yes _____ No _____
Mailing Address: _____ Apt. # _____ City _____ State ____ Zip _____
Home Phone # _____-_____-_____ Cell Phone # _____-_____-_____
Work Phone # _____-_____-_____ Message Phone # _____-_____-_____
Parent in School/Training: Yes _____ No _____ Student Status: Full Time _____ Part Time _____
School's Name _____ Course of Study _____
Do you have a Degree or Certificate? Yes _____ No _____ Date Degree or Certificate achieved _____
In what field? _____
Email Address: _____
Are you pregnant? Yes _____ No _____ Expected Due Date: _____/_____/_____

Family Assistance Information:

How did you find out about the Head Start/Early Head Start Program? (Circle all that apply)
Newspaper _____ TV/Cablecast _____ Flyer/Pamphlet _____ Word of Mouth _____ Friends _____
Family _____ DHS _____ WIC _____ HUD _____ Bench Ad._____ Housing Authority _____ Staff _____
Health Dept. _____ Another Outside Agency _____ _____
Other _____

Do you receive assistance? Yes_____ No _____ (Check all received below.)
HUD _____ SNAP (Food Stamps) _____ TANF/TEA _____ WIC _____
Do you receive Voucher Subsidies for Childcare? Yes _____ No _____

Do you receive any of the following? VA _____ SSI _____ SS _____
If yes, who is it for? Parent 1 _____ Parent 2 _____ Both Parents _____ Sibling _____ Enrolling Child _____
(Please supply documentation if for parent or enrolling child.)

Do you receive Child Support? Yes _____ No _____ If yes, how often do you receive it? _____
Who is it for? _____ Is it for the child you are enrolling? Yes _____ No _____
(If yes, please supply documentation.)

Were you unemployed last year? Yes _____ No _____ If yes, for how long? _____
Did you receive Unemployment pay? Yes _____ No _____ If yes, how much did you receive? _____
(If yes, please supply documentation.)

Do you receive any of the below services from Community Services Office:
Emergency Assistance Program Yes _____ No _____
Emergency Medical Prescription Yes _____ No _____
Employment Assistance Yes _____ No _____
Food Pantry Yes _____ No _____
Low Income Home Entergy Assistance Program (LIHEAP) Yes _____ No _____
Rental Assistance Yes _____ No _____
Transportation (Elderly/Disabled) Yes _____ No _____
Utility Assistance (Other than LIHEAP) Yes _____ No _____
Quarterly Commodities Distribution Yes _____ No _____

Physical Examination:
A physical examination by a physician is required. This exam must include age-appropriate Lead and Hemoglobin/ Hematocrit (blood work) tests. A TB assessment may be conducted if this child is considered to be at risk. If you do not have a copy of a current physical exam for your child, you will be asked to take your child to the doctor to obtain one. This should be completed before your child is enrolled.

Is a copy of child's physical exam included with this application? Yes _____ No_____
Doctor/Clinic Name _____
Business Address: _____ City _____ State _____ Zip _____
Phone # _____-_____-_____ Fax # _____-_____-_____
Date of child's last physical examination: _____/_____/_____ My child has no doctor at this time: _____

Immunization:
Before your child can be enrolled into Head Start/Early Head Start, we must be provided an authorized record of up-to-date immunizations or documentation of a religious or medical exemption from the Arkansas Dept. of Health and Human services.

Child's shot record verified by: Health Dept. Record _____ Physician's Record _____ Other _____

Disability/Disease History:
Circle any your child currently has or has had in the past:

Asthma	Autism	Anemia
Chicken Pox	Diabetes	Drugs
Ear Infections (frequent)	Emotional/Behavioral	German Measles
Heart Defect	Learning Disability	Measles
Mental Retardation	Mumps	Orthopedic Impairment
Obesity (overweight)	Speech/Language	Throat Infections
(frequent) Tuberculosis	Visual Impairment	Whooping Cough

Has your child been diagnosed by a professional for the items circled above? Yes _____ No _____
Does your child have an Individualized Education Plan (IEP or IFSP)? Yes _____ No _____
Is your child currently receiving services from another agency? Yes _____ No _____
If yes, please list agency: _____
Does your child have food allergies? Yes _____ No _____ When was your child's last attack? _____
If so, to what? _____
Other special health needs or comments: _____

Medical Information:

Dental Examination:

An age-appropriate dental exam by a dentist is required. If you do not have a copy of a current exam for your child, you will be asked to take your child to the dentist to obtain one. This should be completed before your child is enrolled.

Is a copy of child's dental exam included with this application? Yes _____ No_____
Dentist/Clinic Name _____
Business Address: _____ City _____ State _____ Zip _____
Phone # _____ /_____ /_____ Fax # _____ /_____ /_____
Date of child's last dental exam: _____/_____ /_____ My child has no dentist at this time: _____

Birth Information:

Was child premature? Yes _____ No _____ Expected Due Date _____ Birth Weight _____
While in the hospital, did the child experience any complications? Yes _____ No _____
If yes, explain: _____
Other useful information _____

Social/Emotional Development:

Physical or emotional problems the child might have: _____
Child's special food needs: Formula _____ Diabetic Diet _____ Allergies_____
Special concerns: Medications _____ Seizures _____ Fainting Spells _____ Eating _____ Bed Wetting _____
Is child toilet trained? _____ Words used in toileting _____
Requires help: Dressing _____ Undressing _____ Toileting _____ Eating _____ Washing Hands _____
Favorite: Games _____ Toys _____ Foods _____
Type of Childcare used before _____

Does your child have trouble with any of the following? (Circle any that apply to your child.)

getting along with other children their same age	aggressive behavior
getting along with other family members	extreme shyness
problems separating from parents/guardians	severe fears
problems sleeping	temper tantrums
child abuse or neglect	death of immediate family member

Is your child receiving mental health services? Yes _____ No _____
Do you have any other concerns about your child or his/her behaviors? Yes _____ No _____
If yes, what concerns do you have? _____
_____

Living Situation:

How long has family lived in this county? _____, At your present address? _____
Do you plan to relocate from this county? Yes _____ No _____ If yes, when: _____
Who, living in the home, does your income support? (List below)

	Name	Birthdate			Name	Birthdate
1	Parent 1:			6	Child:	
2	Parent 2:			7	Child:	
3	Enrolling Child:			8	Child:	
4	Child:			9	Child:	
5	Child:			10	Child:	

Total number of people supported by Parent's Income combined: _____
If Single: Total number of people supported by Legal Guardian's Income: _____

Presently, where is this child living? _____
Type of housing: Apartment ___ Duplex ___ House ___ Mobile Home ___
Do you consider yourself homeless/Moving place to place? Yes _____ No _____
If yes, where are you sleeping? (Check one)
In a shelter_____, In a motel/hotel_____, in a car_____, campsite_____,
With more than one family, in a house or apartment for economic reasons_____
With friends or family members (other than parent/legal guardian) for economic reasons _____
None of the above_____ (Question addresses the McKinney-Vento Act)

Do you live with someone? Yes _____ No _____ Is someone living with you? Yes _____ No _____

List other persons presiding in the home not listed in 1-8 above:			
	Name	Birthdate	Relationship to Child
1			
2			
3			
4			
5			
6			

Total numbers of persons living in this household: _____

Authorization for Release of Records

To Whom It May Concern:

I do hereby give my permission for (Name of Business) _____

Address_____ City_____ State_____ Zip_____

to release the following contained in their files concerning my child's to:

Community Services Office, Head Start/Early Head Start
Attention: ERSEA Director
P.O. Box 1175, Hot Springs, AR 71902
Office: 501-624-5724 Fax: 501-624-1645

I authorize the release of any medical information necessary to meet this request. Such release may include information concerning communicable or venereal diseases including, but not limited to diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency virus, aka Acquired Immune Deficiency Syndrome (AIDS).

Signature of Legal Guardian _____ Date_____

Signature of Witness _____ Date_____

Identifying Information:

Child's Name: _____

DOB _____/_____/_____ SSN#_____-_____-_____

Most recent Physical Examination Date: _____/_____/_____

Most recent Dental Examination Date: _____/_____/_____

Most recent Diagnostic Evaluation Date: _____/_____/_____

Information Needed:

_____ Birth Certificate

_____ Social Security Card

_____ Hematocrit percent

_____ Copy of Medical, ARKIDS, or Insurance Card

_____ Proof of Income for the year _____

_____ Physical Exam including Lead & Hematocrit percent

_____ Shot Record

_____ Lead percent

_____ Dental Screening

_____ Physical Screening

Eligibility Verification

Child's Name: _____

Child's Date of Birth: _____/_____/_____ Is this child eligible to participate in HS/EHS? Yes _____ No _____

Interview: In Person _____ By Phone or Video _____ Date/Time of Interview: _____/_____/_____, _____:_____ a.m./p.m.

- Check the applicable category of eligibility for this child:
  - _____ Income below 100% of federal poverty guidelines
  - _____ Income between 100% and 130% of federal poverty guidelines (35% of slots per grant)
  - _____ Over income, above 130% of the federal poverty guidelines (10% of slots per grant)
  - _____ Public Assistance (TANF, SSI, SNAP)
  - _____ Homeless
  - _____ Foster Care

- What documentation was used to determine applicable category of eligibility?
  - _____ Income Tax Form 1040
  - _____ W-2
  - _____ TANF documentation
  - _____ SSI documentation
  - _____ SNAP documentation
  - _____ Pay Stub or earnings statements
  - _____ Unemployment documentation
  - _____ Written Statement from employer or service provider
  - _____ Foster Care reimbursement
  - _____ Family Signed No Income Declaration (If this item is checked, complete box below.)
  - _____ Other (If other, please explain.) _____

- Complete the following interview questions only if family states that they have **NO** income.
  How is family managing to secure?
  - Shelter _____
  - Food _____
  - Personal Necessities _____
  - Other _____

Parent/Guardian Signature _____ Staff Signature: _____

ERSEA Coordinator Signature: _____ Date of eligibility verification: _____/_____/_____