# USD Head Start
# Enrollment Application

414 E Clark Street
Noteboom Hall
Vermillion SD 57069
www.usd.edu/headstart

605-658-3810
800-813-8132
FAX 605-677-6597

**For Office Use Only:** Application for: ☐ **Early Head Start** ☐ **Head Start**

Acceptance Date: _____ Enrollment Date: _____

Entry Date: _____/_____/_____ Age: _____

Home Visitor/Classroom_____ Application Processed by _____

Eligibility: ☐ Categorically Eligible ☐ Public Assistance ☐ Income eligible ☐ 100-130% ☐ Over- Income

***Please complete application thoroughly. Information provided helps to determine placement.***

**Child Information:**

| First Name | Middle Name | Last Name | Date of Birth: | Gender: ☐ Male ☐ Female |
|---|---|---|---|---|

| **Address where child resides:** | | | **Mailing Address:** | | |
|---|---|---|---|---|---|
| Street: | | | Street/PO Box: | | |
| Town/City: | State: | Zip Code: | Town/City: | State: | Zip Code: |
| County: | | | School District: | | |

**Child lives with:**
**(Check all that apply)**
- ❑ Mother
- ❑ Father
- ❑ Stepfather
- ❑ Stepmother
- ❑ Foster Parent
- ❑ Legal Guardian
- ❑ Grandparent(s)
- ❑ Other, specify: _____

**Parent's Marital Status:**
- ❑ Single
- ❑ Married
- ❑ Divorced
- ❑ Separated
- ❑ Widowed
- ❑ Other _____

**Parent Health Insurance:**
Do you have health care insurance?
Parent/Guardian 1: ☐ yes ☐ no
Parent/Guardian 2: ☐ yes ☐ no

**Language(s) spoken in the child's home?**
Child's Primary: _____
Secondary: _____
How well does the child speak English? _____
Is your child learning a new/additional language?
☐ yes ☐ no
Parent 1 Primary: _____
Parent 2 Primary: _____
Preferred Language: _____

**Is this child currently enrolled in USD Head Start?**
☐ yes ☐ no
☐ Early Head Start
☐ Head Start

**Is another member of your family currently enrolled in USD Head Start?**
☐ yes ☐ no
☐ Early Head Start
☐ Head Start

**Household Composition: List the primary caregivers.**

**Parent/Guardian 1:**

| First Name | Middle Name | Last Name |
|---|---|---|
| Date of Birth: | Relationship to child: | |

**Telephone Number Information:**
Home: _____ Work: _____
Cell phone: _____ Message: _____
E-mail: _____

**Address if different than above:**

**Are you employed:**
☐ Part time ☐ Full time ☐ Seasonally ☐ Retired ☐ Disabled
☐ Unemployed ☐ Self-employed Start Date: _____
Employer Name: _____
**Highest level of education completed:**
☐ 9th grade or less ☐ 10th grade ☐ 11th grade
☐ High School Graduate ☐ GED ☐ Training Certificate
☐ Associates ☐ Bachelor ☐ Masters
☐ Advanced/Doctorate ☐ Other_____
**Are you attending school/job training?** ☐ Yes ☐ No
If yes, where? _____
**Are you in the United States military?** ☐ Yes ☐ No ☐ Veteran

**Parent/Guardian 2:**

| First Name | Middle Name | Last Name |
|---|---|---|
| Date of Birth: | Relationship to child: | |

**Telephone Number Information:**
Home: _____ Work: _____
Cell phone: _____ Message: _____
E-mail: _____

**Address if different than above:**

**Are you employed:**
☐ Part time ☐ Full time ☐ Seasonally ☐ Retired ☐ Disabled
☐ Unemployed ☐ Self-employed Start Date: _____
Employer Name: _____
**Highest level of education completed:**
☐ 9th grade or less ☐ 10th grade ☐ 11th grade
☐ High School Graduate ☐ GED ☐ Training Certificate
☐ Associates ☐ Bachelor ☐ Master's
☐ Advanced/Doctorate ☐
Other_____
**Are you attending school/job training?** ☐ Yes ☐ No
If yes, where? _____
**Are you in the United States military?** ☐ Yes ☐ No ☐ Veteran

**Other Household Member Information: Please list all *other* persons living within the home not listed above.**

| First Name Last Name | Date of Birth | Relationship to child | If an adult, does this person provide support for the child? (i.e. money, shelter, clothing, etc.) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Child's name:**

**Family Resource Information:**

**Does your family receive any of the following types of services or financial assistance? (please indicate all that apply)**

- ❑ TANF **
- ❑ Supplemental Security Income (SSI)**
- ❑ Social Security Disability Income (SSDI) **
- ❑ Child support payments/alimony **
  Is it up to date? _____
- ❑ Unemployment Insurance **
- ❑ Adoption subsidy**
- ❑ Financial Aid Award Letter **
  (Grants and/or Scholarships)
- ❑ SNAP/Food Stamps**
- ❑ WIC County_____
- ❑ Other_____
- ❑ Receiving no services

****Please provide documentation**

**What is your current living arrangement/situation:** ☐ Own ☐ Rent ☐ Motel ☐ Shelter/Mission ☐ Receive Subsidized Housing
☐ Live with others due to loss of housing, economic hardship, or similar reason
☐ Live with Relatives/Friends by choice
☐ Other, Specify _____ How long have you lived at this address: _____

**Does your family currently have reliable means of transportation?** ☐ Yes ☐ No _____Number of vehicles
If yes, please specify: ☐ Private vehicle ☐ Friend's or relative's vehicle ☐ Public transportation ☐ Other: _____

**Are there any family situations, concerns or other crisis that we should be aware of to help meet the child's needs (such as recent divorce, parental health, counseling, recent moves, substance misuse/exposure, parent absent because they are in the military, incarcerated, etc.)?** ☐ Yes ☐ No If yes, please explain:

**Is there any family or household member who has a serious health concern (i.e. diabetes, cancer, autism, ADHD, substance abuse/ exposure, depression, bipolar, etc.)?** ☐ Yes ☐ No If yes, please explain:

**Custodial Information:**

- ❑ Does not apply in my situation
- ❑ Sole Custody
- ❑ Joint Custody—both biological parents
- ❑ Joint Custody—other; explain _____
- ❑ Physical Custody: explain who has custody _____
- ❑ Foster Care/Custody of State of South Dakota
  Caseworker: _____
  Agency: _____
  Phone & E-mail: _____

**Is there a protection or restraining order regarding the child?**
- ❑ No
- ❑ Yes (Please explain and provide a copy upon acceptance)

**Are there special visitation orders?**
- ❑ No
- ❑ Yes (Please explain and provide a copy upon acceptance)

**Additional Information:**

**Is anyone in your household currently pregnant?** ☐ Yes ☐ No Due Date: _____

If you are pregnant, would you like ☐ an application ☐ information for the USD Head Start services for expectant families?

☐ Not interested at this time.

**For Office Use Only** **Verification**

**Family Size**_____ **Family Income** _____

**Witness: 1.** _____ **Position:** _____ **Date:** _____

**2.** _____ _____ _____

**Re-verification**

**Family Size**_____ **Family Income** _____

**Witness: 1.** _____ **Position:** _____ **Date:** _____

**2.** _____ _____ _____

**Child's name:**

## Health, Nutrition & Developmental Information

| **Child's Physician/Health Care Provider Name:** | **Address:** | **Date of Last Exam:** |
|---|---|---|
| | | |

**Health Care Coverage Information:**
☐ CHIP/Medicaid ☐ Indian Health Service ☐ Private Health Insurance ☐ Tri-Care ☐ No Health Care Coverage

| **Child's Dentist/Dental Care Provider Name:** | **Address:** | **Date of Last Exam:** |
|---|---|---|
| | | |

**Dental Care Coverage Information:**
☐ No Coverage ☐ CHIP/Medicaid ☐ Dental Insurance_____

**Does the child have any health-related concerns or conditions?**
For example: asthma/reactive airway disease, diabetes, failure to thrive, high lead levels, anemia, disabling conditions, pre-mature birth, mental health issues, seizures/seizure disorder, or other chronic health conditions. ☐ Yes ☐ No
Are they diagnosed by a health care professional? ☐ Yes ☐ No
If yes, please explain: _____

**Does the child have any allergies?**
For example: foods, medications, environmental, seasonal, insect bites. ☐ Yes ☐ No
Are they diagnosed by a health care professional? ☐ Yes ☐ No Is there an emergency protocol in place? ☐ Yes ☐ No
If yes to any of the allergy questions, please explain: _____

**Does the child have any current special dietary needs or nutrition concerns?** ☐ Yes ☐ No If yes, please explain**:**

_____

**Do you have any concerns about your child's development?** ☐ Yes ☐ No If yes, please explain:

_____

**Has the child been diagnosed with a disability?** ☐ Yes ☐ No If yes, please explain**:**

_____

**Is the child receiving any special services or currently on an IEP (Individual Education Program/Plan) or IFSP (Individual Family Service Plan)?**
(i.e. medical, speech therapy, physical therapy, occupational therapy, early childhood special education, counseling, etc.)
☐ Yes ☐ No If yes, please provide name and address of service provider

Provider:_____Phone:_____Address:_____

| **Release of Information (PLEASE USE INITIALS)** | **Yes** | **No** |
|---|---|---|
| **I give consent for the program to obtain my child's immunization records from the South Dakota Immunization Information System upon acceptance.** | | |
| **I give consent for my child's first name, last name, gender, date of birth, race/ethnicity, start and end date of Head Start services to be entered into the State of South Dakota Department of Education's student information system upon enrollment.** | | |
| **I give consent for the child's name and date of birth to be released to the school districts, education cooperatives, preschool and daycare providers that are in a partnership with the USD Head Start program.** ***Authorized consent to the 3 questions above is valid as long as this application remains active.*** | | |

**Referred By:**

- ❑ Health Care Provider/Dentist
- ❑ WIC Office/County Health
- ❑ School, Early Childhood or Birth –Three Program
- ❑ Friend or Relative
- ❑ Department of Social Services
- ❑ Dept. of Labor (Career Center)
- ❑ Other Head Start Program
- ❑ Newspaper
- ❑ Church
- ❑ Poster/Sign
- ❑ Social Media (Facebook, etc.)
- ❑ Head Start Staff
- ❑ Program Brochure
- ❑ Head Start Mailing
- ❑ Other

Specify: _____

**The statements and information on this application are true and accurate to the best of my knowledge.**

** ***To process your application we need proof of <u>age</u> and a <u>form of income verification</u>.***
*To verify income please include last year's income tax return, W-2 form, Financial Aid Award Letter, TANF Documentation, SSI Documentation, Child Support Documentation, or pay stubs. Please include a copy of the child's immunization record and birth certificate if available.*

**Parent Signature :** _____ **Date :** _____

**Parent Signature :** _____ **Date :** _____

Updated: Jan 2023