



**Iowa Tribe of Oklahoma  
Early Head Start  
2011-2012 Application**

Rt. 1 Box 721  
Perkins, Oklahoma 74059  
(405) 547-4261  
Fax: (405) 547-1105

Thank you for your interest in the Iowa Tribe of Oklahoma Early Head Start. In order for us to determine eligibility, all information needs to be filled in to the best of your ability and the information listed below needs to be attached. You will then be notified in writing if a slot is available for your child or further information is needed.

**Set Selection Criteria will be used when determining enrollment priority of infants and toddlers. When filling a slot, the age of the child to be selected is determined by the vacancy of the 'age group' for center-based services.**

**Be sure all necessary documentation is enclosed before application is submitted**

1. Iowa Tribe of Oklahoma Early Head Start Application
2. Copy of the child/parent CDIB card
3. Copy of child's state-issued birth certificate or the hospital
4. Copy of child's up-to-date immunization record
5. Income verification
  - Recent income for a month period (for review only)
  - 1040 Income Tax
  - Public assistance award letter
  - Verification of wages and hours worked from employer
  - SSI documentation
6. Payment contract and verification of child care assistance
7. Copy of parent work or school schedule
8. The child's social security card
9. Insurance card (If Applicable)
  - Medicaid
  - United Health Care
  - Blue Cross Blue Shield
  - None
  - Other \_\_\_\_\_
10. Proof of residence in Payne, Lincoln or Logan Counties
  - Utility bill
  - Public assistance award letter
  - Lease Agreement
  - Letter from center director (Shelters)



## CHILD INFORMATION

*(If child NOT born yet, skip this page)*

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  Male  Female  
NAME OF CHILD APPLYING FOR EARLY HEAD START      DOB      AGE

\_\_\_\_\_  
ADDRESS (IF DIFFERENT FROM PARENT/GUARDIAN)      CITY/STATE      ZIP

**What race/ethnicity do you consider this child to be? (Check one)**

- White/Anglo     Black/African American     Native American     Asian     Pacific Islander  
 Latino/Hispanic     Multi-racial or Other (specify): \_\_\_\_\_

**Where does the child go for checkups, shots, and other health care? (Please list all):**

**Do you or anyone else have any concerns about this child's overall health, development, learning or behavior?**

- YES     NO  
If yes, please describe:

**Has anyone expressed concerns or recommended services based on this child's health, learning, development or behavior?**

- No     Yes, family member     Yes, Pediatrician/health professional: \_\_\_\_\_  
 Yes, teacher     Yes, Child Service Coordinator or other case worker: \_\_\_\_\_

**Has the child received any developmental screening, assessment or evaluation because of concerns about his/her behavior, health or development, or for early intervention or special education services?**

- No (skip the next question)     Yes, Health Department     Yes, Pediatrician     Yes, Hospital  
 Yes, Psychologist Social Worker     Yes, SoonerStart     Yes, other: \_\_\_\_\_

**If yes, did the evaluation result in eligibility for the child to receive early intervention services (such as therapy, special education, speech services)?**     Yes     No     Unsure

**Does your child have an IFSP (Individualized Family Service Plan)?**     Yes     No     Unsure

## PARENT & FAMILY INFORMATION

The information on this application is being requested from you on a voluntary basis, and will help us to best direct program services to meet your family's needs. If you prefer not to provide some of the information, it will not change the services we try to deliver; however, some information is required to determine whether you are eligible for Early Head Start. All information will be held in strict confidence according to program policy.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**NAME OF ADULT APPLYING FOR CHILD**                      **RELATIONSHIP TO CHILD**                      **TODAY'S DATE**

\_\_\_\_\_  
**HOME ADDRESS**                                      **CITY/STATE**                                      **ZIP CODE**                                      **HOME PHONE**

**How long has this child lived at this address?** \_\_\_\_\_

\_\_\_\_\_  
**MAILING ADDRESS FOR CHILD (If different from above)**                      **OTHER PHONE NUMBER**

**IF YOU ARE PREGNANT:** Due Date (mm/yy): \_\_\_\_/\_\_\_\_                      Are you receiving prenatal services?  Yes  No

**FAMILY INFORMATION:**                                      **Mother/Legal Guardian**                                      **Father/Legal Guardian**

<b>Name:</b>		
<b>Date of Birth:</b>		
<b>What Race/Ethnicity do you consider yourself to be? (check one)</b>	<input type="checkbox"/> White/Anglo <input type="checkbox"/> Black/African American <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Multi-racial or Other (specify): _____	<input type="checkbox"/> White/Anglo <input type="checkbox"/> Black/African American <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Multi-racial or Other (specify): _____
<b>Languages Spoken:</b>		
<b>What is the primary language spoken in your home?</b>		
<b>What is your employment situation? (check one)</b>	<input type="checkbox"/> Full-time (30 +hours) <input type="checkbox"/> Part-time (29 hrs or less) <input type="checkbox"/> Farm/Seasonal Worker <input type="checkbox"/> Homemaker <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Unable to work due to disability <input type="checkbox"/> In Job-training program: _____ <input type="checkbox"/> Self-employed (specify): _____ <input type="checkbox"/> Actively seeking employment <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Full-time (30 +hours) <input type="checkbox"/> Part-time (29 hrs or less) <input type="checkbox"/> Farm/Seasonal Worker <input type="checkbox"/> Homemaker <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Unable to work due to disability <input type="checkbox"/> In Job-training program: _____ <input type="checkbox"/> Self-employed (specify): _____ <input type="checkbox"/> Actively seeking employment <input type="checkbox"/> Other (specify): _____
<b>If employed, how long have you been in your current job?</b>		
<b>Place of employment:</b>		
<b>Work Phone #'s:</b>		
<b>Hours worked:</b>	From:                                      To:	From:                                      To:
<b>Paid: Wkly, Bi-Wkly, Twice a M. or Monthly</b>		
<b>Enrolled in School?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No    Where?	<input type="checkbox"/> Yes <input type="checkbox"/> No    Where?
<b>Last School Grade Completed:</b>	Date:	Date:
<b>HS Diploma/GED Received?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Family Information continued:**

Name of Head of Household: \_\_\_\_\_

Are both parents involved in raising this child?  Yes  No

Is this child a foster child?  Yes  No

Who has LEGAL custody of the child: \_\_\_\_\_

Are there custody issues?  Yes  No

If so, please explain : \_\_\_\_\_

Are you (check one):  Single  Married  Separated  Divorced  Widowed

Who does the child live with?  Both Parents  Father  Mother

Foster Parents  Grandparent(s)  Other \_\_\_\_\_

Who else lives in the home with this child? (Brothers, sisters, aunts, uncles, grandparents, non-relatives, etc.):

NAME	SEX	AGE	DATE OF BIRTH	RELATIONSHIP TO CHILD

**Family Risk Factors**

The next questions include topics that are more sensitive. Please share as much information as you are comfortable giving at this time. These are questions we ask of any family applying for our program. The more information you share with us, the better we can score your child's application. **All information in this application is kept confidential.**

Do you have trouble meeting your child's basic needs such as housing, healthcare, and/or food?  Yes  No If yes, please explain: \_\_\_\_\_

Have you or your child witnessed alcohol or drug abuse in your household?  Yes  No If yes, please explain: \_\_\_\_\_

Has your child witnessed physical or verbal violence in your community?  Yes  No

Has your child witnessed physical or verbal violence in your home?  Yes  No

Are you homeless or live in a shelter?  Yes  No

Do you feel that your house and/or neighborhood are safe?  Yes  No

Have you had problems in the past with keeping a house or an apartment?  Yes  No

Does any family member living within your home have a documented disability?  Yes  No

Is this family member receiving SSI (Supplemental Security Income) for disability?  Yes  No

Does either parent have a mental illness?  Yes  No Is the parent receiving SSI for mental illness?  Yes  No

Has your child recently lost one of his/her parents due to death or imprisonment?  Yes  No

Or due to separation, divorce or abandonment?  Yes  No

Has your family ever been involved with Child Protective Services (CPS)?  Yes  No

Is there documented abuse or neglect?  Yes  No

Have you ever lost custody of your child?  Yes  No or voluntarily placed him or her in another home?  Yes  No

Do you or your child feel isolated; have little opportunity to interact with others?  Yes  No

Have there been any other serious events, which have put stress on your family recently?  Yes  No If so, please explain: \_\_\_\_\_

Does your child have a sibling that is currently enrolled in Early Head Start or Head Start?  Yes  No

Does your child have a sibling that was previously enrolled in Early Head Start or Head Start?  Yes  No

Was either parent enrolled in Early Head Start or Head Start as a child?  Yes  No

What kind of transportation do you use? (my car, bus, family/neighbors, etc.): \_\_\_\_\_

Does your family receive any of the following services or assistance? (Check all that apply):

- Medicare       Soonercare       TANF/Public Assist.       Unemployment  
 SSI       Housing Assistance       Dept. of Social Services--Subsidy       Foster Care  
 WIC       Food Stamps       Child Care Assistance--Subsidy       Child Support  
 Other(s): \_\_\_\_\_

Are other community agencies providing services to you or anyone else living in your house?  Yes  No  
 If yes, please list below.

AGENCY	PERSON'S NAME

I am interested in...

- Expectant Families Program  
 Center-based services (in a classroom)

Why do you want your child to be in Early Head Start?

- I need childcare to continue working \_\_\_\_\_ hours per week.  
 I need childcare to find a job.  
 I need childcare to return to school/job training/other training  
 (explain): \_\_\_\_\_  
 My current childcare arrangements are not meeting our needs.  
 (explain): \_\_\_\_\_  
 I want my child to spend time with other children.  
 I would like parent education.  
 Other: \_\_\_\_\_

Will you be utilizing Early Head Start Hours (9-3 p.m.) or before and after care (please specify)? From: \_\_\_\_\_ To: \_\_\_\_\_

Are you already receiving childcare subsidy?  Yes  No If yes, check one:  DHS  Tribal

If no, have you applied for childcare subsidy?  Yes  No If yes, check one:  DHS  Tribal DATE: \_\_\_/\_\_\_/\_\_\_

Is your child attending a childcare center?  Yes  No

My child is currently enrolled at: \_\_\_\_\_

Please tell us how you found out about our program. This will help us understand the best ways to reach out to families in our community (check one):

- Newspaper  
 A posted flyer/sign I saw (where?): \_\_\_\_\_  
 From a friend/neighbor/family member \_\_\_\_\_  
 From someone who works with the family (who?) \_\_\_\_\_  
 Other: \_\_\_\_\_

**I CERTIFY THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS ACCURATE AND TRUTHFUL TO THE BEST OF MY KNOWLEDGE.**

\_\_\_\_\_  
Parent/Legal Guardian's Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

**WHAT'S NEXT....**

You will receive a letter to confirm the status of your application or an email with the confirmation attached if you wish for us to correspond via the internet. We will let you know if we need more information. We will need to be able to communicate with you as we determine your child's eligibility and possible placement in our program. **Please contact us if your address, income, phone number(s) or other family information changes.** If there is a friend/family member who can help us get in touch with you about the status of your application, please put his or her name(s) and phone number(s) below:

\_\_\_\_\_  
Parent (s) Name

\_\_\_\_\_  
Email

Friends/Relative:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number

Iowa Tribe of Oklahoma Early Head Start  
**Application Consent for Exchange of Information**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

The Iowa Tribe of Oklahoma Early Head Start program operates in partnership with community agencies serving children and families. These partnerships help us to promote access to support programs for families who are eligible to receive them. Your consent for our program staff to discuss your child's needs with other agencies will help to ensure that our services to your family are efficient and unified with other services your family may receive.

**NOTE: Eligibility for the Early Head Start program will not result in the loss of services you already receive.**

We may need to exchange information contained in this application with the following:

- Local Health Department
- Department of Social Services (DSS)--TANF, Day Care, Child Protective Services or Indian Child Welfare
- Oklahoma DHS--Subsidy
- WIC
- SoonerStart-Early Intervention
- Other(s) (Please Complete) \_\_\_\_\_

\_\_\_\_\_

**CONSENT TO EXCHANGE INFORMATION WITH CHILD'S HEALTH CARE PROVIDERS:**  
Please list your child's pediatricians and any other place your child is seen for health care or specialty care:

- Doctor's Office/Health Care Center (please specify): \_\_\_\_\_
- Other Health Care Provider (please specify): \_\_\_\_\_

I give my consent for the Iowa Tribe of Oklahoma Early Head Start program to exchange information with the agencies listed above. I understand that this consent is voluntary and is valid until my child is no longer enrolled in the Iowa Tribe of Oklahoma Early Head Start program, or until I cancel this release in writing. I understand that this page of my application may be faxed to the above agencies to show my consent for this release and I release all health care providers of any liability while corresponding using any method of communication for example by phone or by fax.

\_\_\_\_\_  
Parent/Legal Guardian's Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

