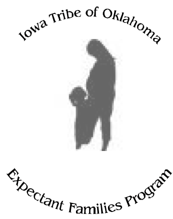

Iowa Tribe of Oklahoma
Expectant Families Program
Enrollment Information FY 2011-2012

Expectant Mother,

Thank you for your interest in the Iowa Tribe of Oklahoma Early Head Start *Expectant Families Program*. In order for us to determine your eligibility we need the following information.

- ☐ **Application** (pages 1-3 completed and signed)
- ☐ **Proof of income for each adult member of your family**. Submit ONE of the following: *If applicant is a teen and not working, skip to the next section.*
  - Recent income for a month period
  - Income tax statement
  - Public Assistance award letter for TANF
  - Verification of wages signed by employer
  - SSI
- ☐ **Proof of residency for your family**- a document with your name and current mailing address (*Must live in Payne, Lincoln, or Logan counties*). Submit ONE of the following: (examples)
  - Utility bill
  - Cable bill
  - Public Assistance award letter for Food Stamps
  - Public Assistance award letter for TANF
  - SSI
- ☐ **CDIB** (if applicable)

**Above documents must be submitted before your application can be evaluated. Please submit copies only.*

We look forward to receiving your application! You can either mail or deliver your documents by using the information below. If you have any questions or need assistance contact Diana Cates at 405-547-4261.

Deliver application to:

Eagle's Nest, which is the farthest north building when entering the Iowa Tribe of Oklahoma Complex.

Mail application to:

Attn: Diana Cates Iowa Tribe of Oklahoma
RR 1 Box 721
Perkins, OK 74059

Expectant Families Program
Application for Enrollment

Date ______________ How did you find out about our program? ___________________

Family Information

Expectant Mother ____________________________ Phone __________________
Birth Date (Month/Day/Year)_________________ Email ___________________
Physical Address ______________________City______________ Zip _______________
Mailing Address ______________________City______________ Zip ______________
Race ___________________________ Language(s) Spoken ____________________
CDIB ☐ Yes ☐ No If yes, list tribe____
Employer/School____

Expectant Father ____________________________ Phone __________________
Birth Date (Month/Day/Year)___________________ Email__________________
Physical Address ______________________City______________ Zip _______________
Mailing Address ______________________City______________ Zip ______________
Race ___________________________ Language(s) Spoken ____________________
CDIB ☐ Yes ☐ No If yes, list tribe____
Employer/School____

☐ One-Parent Family ☐ Two-Parent Family ☐ Teenage Mother

Number in Household (including baby) __________ Marital Status _________

Prenatal Information

What week of pregnancy? _________ What is your expected due date? ______________

Any complications with your current pregnancy? ☐ Yes ☐ No
If yes, describe ____

Any complications with previous pregnancies? ☐ Yes ☐ No
If yes, describe ____

Do you have a prenatal provider (doctor for your pregnancy)? ☐ Yes ☐ No
Name________________________________Address_________________________________
Phone_______________________________ Date of last visit________________________

Income Information

Does your family receive any of the following services or assistance?
☐ TANF ☐ Child Support ☐ SSI ☐ WIC
☐ Housing Assistance ☐ Child care assistance ☐ Sooner Care ☐ Unemployment
☐ Food Stamps ☐ Social Services financial assistance ☐ Foster care
☐ Other____

Family's Gross Income (include SSI if applicable):
Weekly $_______________ or Monthly $________________ or Yearly $________________

Enrollment Priority is given to eligible families who have special circumstances. Please check any circumstances that apply to your family.

Family

___ Diagnosed Disability, if yes list ____
___ Suspected Disability, if yes list ____
___ Teen Pregnancy
___ Medical Concerns
___ Nutritional Concerns
___ English as Second Language
___ Single Parent (in school or working)
___ Blended Family
___ Unemployed
___ Limited Resources
___ Recent Divorce or Separation
___ Deceased Parent
___ Domestic Violence
___ Substance Abuse
___ Homelessness
___ Major Change in Family
___ Home Safety Hazards
___ Other, explain____

Current and Previous Pregnancies (please check all that apply)

Complications	Current Pregnancy	Previous Pregnancy
Pain		
Bleeding		
C-Section		
Fatigue		
Pre-Term Labor		
Diabetes		
Pregnancy Induced Diabetes		
Anemia		
Headaches		
Swelling		
Sickle Cell		
Hypertension		
Pregnancy Induced Hypertension		
Neonatal Death		
Miscarriage		
Bed Rest		
Hospitalization		
Other, list ____ ____		

Signature of Applicant ___________________________________ Date _____________________

Income Verified By: _________________________ **By Viewing:** __________________**Date:** ____________
Income Eligible: ______ **Over-Income:**_______ **Special Circumstances :** ___________________________
Date Enrolled: _________ **Notes:** ____

Consent for the Release of Confidential Information

______________________________	______________________________	______________________________
Expectant Mother	Date of Birth	Social Security #

I authorize: Theresa Ferguson, Iowa Tribe of Oklahoma/Early Head Start Expectant Families Program
RR 1 Box 721, Perkins, OK 74059

Release to: ____
Your Prenatal Provider's Name

Information: Name and date of birth for program planning and completion of the Health Evaluation. I also authorize my prenatal provider to respond by completing the Health Evaluation provided.

I understand these records are protected and confidential and cannot be released without written consent. Expectant Families Program does not disclose any information without a written consent. I also understand I may cancel this consent in writing at any time unless action has already been taken based upon this consent.

____
Expectant Mother Signature

____
Date

(Consent expires after one year)

EF-002
Revised 5/20/10 FY 2010-2011

Prenatal Health Evaluation

Expectant Mother's Name	Birth Date	Expected Due Date	Prenatal Care Provider

Date Patient first received prenatal care	/ /

Yes or No				
Complete For Current Trimester	1st Trimester	2nd Trimester	3rd Trimester	Postpartum
Following recommended schedule of pre/postnatal care				
Medically High Risk (If yes, explain in comments)				
Family History Substance Abuse (including tobacco)				
Family History of Depression				
Concern of Patient depression/postpartum depression				
Nutrition concerns				
Gaining healthy/adequate weight				
Dental concerns				
Other				
Additional Comments: (Include Date)				

Health Care Name & Title (Print)	Health Care Signature	Date
Expectant Families Specialist (EFS)	EFS Signature	Date Reviewed
Health Care Name & Title (Print)	Health Care Signature	Date
Expectant Families Specialist (EFS)	EFS Signature	Date Reviewed

Theresa Ferguson, Expectant Families Specialist
(405) 547-4271
Fax: (405) 547-1105

EF-002
Revised 5/20/10 FY 2010-2011