Class Preference: **please mark one**

❑Home Base
❑Half Day (Child rides bus)
❑Fullday (parent transport)

UTE INDIAN TRIBE HEAD START
2017-2018 Eligibility Application

PO Box 265
Fort Duchesne, Utah 84026
(office) 435-722-4506 (fax) 435-722-5652

*Please **fill out** the form **completely** and accurately. All information will be kept CONFIDENTIAL. The information will be used to help us determine if your family is eligible for Head Start.* Please complete this application and return with:

YOUR CHILD'S BIRTH CERTIFICATE, IMMUNIZATION RECORD, AND INCOME VERIFICATION

Child's Name: _____ Date of Birth:_____
(First, Middle, Last) (**Please attach verification:** Birth Certificate, Hospital Documentation, etc.)

SS#_____

Race: (check all that apply)	❑ Hispanic
❑ Asian ❑ American Indian/Alaskan Native	❑ Non-Hispanic
❑ Black ❑ Hawaiian/Pacific Islander	Nationality
❑ White ❑ Other _____	

Sex: ☐ Male ☐ Female

What language does your child speak most fluently? ☐ English ☐ Spanish ☐ Other: _____
What other language does your child speak? ☐ English ☐ Spanish ☐ Other: _____

Parent or Guardian Information: **(The person signing the application should complete this section)**

Parent or Guardian's Name:_____

Date of Birth: _____ Relationship to child: _____
(Example: Mother, Father, Foster, Grandparent, etc.)

Home: _____ _____ _____
(Address) (City) (zip)
Mailing: _____ _____ _____
(Address) (City) (zip)
Telephone: _____ _____ _____
(home) (work) (cell)
Email Address: _____
In what language do you prefer to communicate? ☐ English ☐ Spanish ☐ Other: _____

Other Parent or Guardian Information:

Parent or Guardian's Name: _____

Date of Birth: _____ Relationship to child:_____
(Example: Mother, Father, Foster, Grandparent, etc.)

Home: _____ _____ _____
(Address) (City) (zip)
Mailing: _____ _____ _____
(Address) (City) (zip)
Telephone: _____ _____ _____
(home) (work) (cell)
Email Address: _____
In what language do you prefer to communicate? ☐ English ☐ Spanish ☐ Other: _____

Family Size and Income

Head Start must know how many people are living in your household and the total family income in order to determine if your family income is at or below the Federal poverty guidelines. Family is defined for this purpose as "all persons living in the same household who are supported by the income of the parent(s) or guardian(s) of the enrolling child and are related to the parents(s) or guardian(s) by blood, marriage, or adoption."

Number in Household _____ Number in Family ____ Total Num. of Children ____ Num. Age 0-3 ____ Num. Age 4-5 ____

Name (First, Middle, Last)	Level of Education	Relationship to child	DOB	Race	Ethnicity
					☐ Hispanic ☐ Non-Hispanic
					☐ Hispanic ☐ Non-Hispanic
					☐ Hispanic ☐ Non-Hispanic
					☐ Hispanic ☐ Non-Hispanic
					☐ Hispanic ☐ Non-Hispanic
					☐ Hispanic ☐ Non-Hispanic

Please select the type of family that best describes that of the child applying to this program:

☐ Single Parent ☐ Two Parent (☐ Married ☐ Biological ☐ Acting Stepparent ☐ Joint Custody)

☐ Foster Parent ☐ Not the Child's Parent Other: _____

Income **(Eligibility is based on the Federal Poverty Guidelines. Proof of income is REQUIRED and must include the total income of all members of the family listed above.)**

Do you receive TANF? (Food Stamps and Emergency Assistance not included) ☐ Yes ☐ No

Do you or any one in your family currently receive Supplemental Security Income (SSI)? ☐ Yes ☐ No

Is this application for a foster child placed with you through Ute Tribe Social Services or the State of Utah? ☐ Yes ☐ No

Is your family currently ***Homeless?*** ☐ Yes ☐ No
(Living temporarily in shelters, hotels, or vehicles; or moving frequently between the homes of relatives and friends)

Please check all sources of income:

Parent/Guardian:

☐ Employment/Job ☐ Military Income

☐ Child Support ☐ Pension

☐ Unemployment ☐ Alimony

☐ Other:_____

Are you receiving assistance from other agencies?

☐ AFDC ☐ SNAP/Food Stamps ☐ WIC

Other Parent/Guardian:

☐ Employment/Job ☐ Military Income

☐ Child Support ☐ Pension

☐ Unemployment ☐ Alimony

☐ Other:_____

Are you receiving assistance from other agencies?

☐ AFDC ☐ SNAP/Food Stamps ☐ WIC

Emergency Contact Information for:_____			
Contact 1	Parent/Guardian	Relationship to child	❑ Emergency Contact ❑ Release Child to
	Address Language_____		Primary
	Phone 1	Phone 2	Phone 3
Contact 2	Name	Relationship to child	❑ Emergency Contact ❑ Release Child to
	Address Language_____		Primary
	Phone 1	Phone 2	Phone 3
Contact 3	Name	Relationship to child	❑ Emergency Contact ❑ Release Child to
	Address Language_____		Primary
	Phone 1	Phone 2	Phone 3
Contact 4	Name	Relationship to child	❑ Emergency Contact ❑ Release Child to
	Address Language_____		Primary
	Phone 1	Phone 2	Phone 3
Contact 5	Name	Relationship to child	❑ Emergency Contact ❑ Release Child to
	Address Language_____		Primary
	Phone 1	Phone 2	Phone 3

Parent / Guardian Signature: _____ Date: _____ / _____ / _____

Transportation *(Head Start makes every effort to provide transportation to as many children as possible. Some families may live outside of the boundaries or live in areas designated as parent transport REQUIRING families to transport their own child to and from school.)*

Would you be able to transport your child to and from school or designated pick up spot? ☐ Yes ☐ No

If my child is on a bus route, I give permission for Ute Indian Tribe Head Start to transport my child to and from school. I have read, understand and will comply with the UIT Head Start Transportation Policy. (included in the application packet)

Parent/Guardian Signature: _____ Date: _____/_____/_____

Pick up/Drop off Address: _____Apt. #_____ City: _____

This address is: ☐ Home ☐ Childcare ☐ Other

Health

Please, Complete Entire Form, Use N/A or None if needed.

Critical Health Notes/Allergies, etc.? _____

DOES YOUR CHILD HAVE FOOD ALLERGIES: ❑ Yes ❑ No **IF YES PLEASE INDICATE ALLERGIES:**

My Child's Doctor and Dentist

If your child is eligible to receive services from Indian Health Services please write IHS below, for both Doctor and Dentist. If your child does not have a Doctor or Dentist please write NONE below.

Doctor Name	Address	City	State	Zip	Phone

Dentist Name	Address	City	State	Zip	Phone

Insurance Information:

Medicaid Eligible?	Indian Health Services Eligible?	Primary Health Coverage	Dental Coverage	Other Health Coverage
❑ Yes	❑ Yes	❑ Yes	❑ Yes	❑ Yes
❑ No	❑ No	❑ No	❑ No	❑ No
Medicaid Number		Insurance Provider	Insurance Provider	Insurance Provider
		Insurance Number	Insurance Number	Insurance Number

If you have any questions or need assistance with completing this application, please contact us at (435) 722-4506.

Consents and Permissions:

By checking the boxes below the parent/guardian gives consent to the Ute Indian Tribe Head Start to perform the following screenings:

(If parent/guardian does not mark one or more of the screenings then the parent/guardian acknowledges responsibility for obtaining that required screening)

Provided by Head Start Staff:

❑ Hearing ❑ Heights and Weights ❑ Vision

❑ Developmental Screenings & Assessments

❑ Treated with emergency care if needed

Provided by Dentist:

❑ Dental Screening ❑ Fluoride Varnish

Provided by Health Care Professional:

❑ Blood Pressure ❑ Physical Exam

Lab Tests: ❑ Urinalysis

Finger Stick: ❑ Lead Screenings ❑ Hematocrit/Hemoglobin

PPD Skin Test: ❑ TB Screening

Permissions

❑ Share health records with the School District you designate:_____

❑ Child may accompany class on field trips

❑ Use of the Child's photograph

❑ I give permission to the Ute Tribe Head Start to release my child's name and any information that may be needed to Uintah School District/Duchesne School District/ Other: _____ School that will help to transition my child into public school.

❑ I give permission to have additional assessment administered if necessary, to Duchesne County / Uintah County Specialized Preschool.

Developmental Concerns:

Does your child have a ***disability***? ❑ Yes ❑ No ❑ Don't know

Describe Concerns: _____

❑ Autism	❑ Emotional Behavioral disorder	❑ Health impairment
❑ Learning disability	❑ Hearing impairment including deafness	❑ Orthopedic impairment
❑ Traumatic brain injury	❑ Speech language impairment	❑ FAS
❑ Developmentally delayed	❑ Visual impairment including blindness	❑Other: _____

Has this been diagnosed? ❑ No ❑ Yes, if yes by whom_____

As part of the Head Start requirements, a Mental Health Professional will observe each classroom and may make referral for further observations.

Income verification (check all that apply) ❑ 1040 Tax Statement ❑ W2 Statement ❑ SSI Statement ❑ Pay stubs ❑ Income Declaration ❑ Public Assistance Form ❑ Foster Care Adoption subsidy ❑ Child Support/Alimony ❑ Unemployment ❑ Other: Specify						
Accept Date Enrolled Date	By(must be signed by 1 HS staff)	Number in Family	Federal Guideline	Yearly Income	Income Eligible? Yes No 2nd Year Eligible? Yes No	Notified? Phone Letter Start Date

Nutritional Assessment

- ❑ Child takes vitamin/mineral supplements?
  - ❑ Supplements contain iron?
  - ❑ Supplements contain fluoride?
  - ❑ Supplements were prescribed?
- ❑ Child has trouble chewing or swallowing?
- ❑ Child on a Special Diet?
- ❑ Change in Child's appetite in the past month?
- ❑ Child takes a bottle?
- ❑ Child eats or chews things that aren't food?
- ❑ Child often has?
  - ❑ Diarrhea?
  - ❑ Constipation?

Usual Food Group Eating Frequency:

(Please indicate 1 to 7+ times per week) Example: Milk __7__; child drinks a glass of milk each day

Milk, cheese, yogurt__
Rice, grits, bread, cereal, tortillas __

Oranges, grapefruit, tomatoes (fruit/juice) __
Oil, butter, margarine, lard __

Meat, poultry, fish, eggs; or dried beans/peas, peanut butter__
Greens, carrots, broccoli, winter squash, pumpkin, sweet potatoes__
Other fruits and vegetables __
Cakes, cookies, sodas, fruit drinks, candies __

Favorite Foods: _____
Least Favorite Foods: _____

Foods not eaten for medical, religious or personal reasons?_____

Concerns about what child eats? _____

I certify the information provided in this application is accurate and truthful to the best of my knowledge, and I authorize Head Start to verify information as needed.

Parent / Guardian Signature: _____ Date: _____ / _____ / _____

Parent / Guardian Signature: _____ Date: _____ / _____ / _____

Ute Indian Tribe Head Start implements a Fatherhood Program, offering opportunities for Fathers to become engaged in their child's education. Activities are held on a monthly basis. Please indicate below if you are interested in being involved in our Fatherhood Program.

❑ Interested ❑ Not Interested