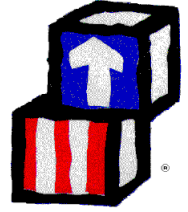


HEAD START of LANE COUNTY

221 B Street, Springfield OR 97477-4522 • 541-747-2425 • (FAX) 541-747-6648 • <http://www.hsolc.org>

"Ensuring that our youngest children have a solid foundation for life."



Eligibility Application (Rev 9/17)

Please fill in the form completely and accurately. All information will be kept confidential. It will be used to help us determine if your family is eligible for services and to prioritize your placement on the waiting list.

If you have any questions about this application, or need any help in completing it, please call us at 541-747-2425.

We will be glad to help!

For Pregnant Applicants:

Pregnant Applicant Name: _____ Due Date: _____
(First, Middle, Last)

For Child Applicants:

Child's Name: _____
(First, Middle, Last)

Date of Birth: _____ **(PLEASE ATTACH VERIFICATION: birth certificate, hospital documentation, etc.)**

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: \_\_\_\_\_  
(First, Middle, Last)

Date of Birth: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_  
(Example: Mother, Father, Foster Father, Grandmother, etc.)

Home: \_\_\_\_\_  
(Address) (City) (ZIP)

Mail *(if different)*: \_\_\_\_\_  
(Address) (City) (ZIP)

Telephone: \_\_\_\_\_  
(Home) (Work) (Message)

E-mail address \_\_\_\_\_

In what language do you prefer to communicate:  English  Spanish  Other \_\_\_\_\_

~~~~~  
Other Parent or Guardian Information

Parent or Guardian's Name: _____
(First, Middle, Last)

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

Home: _____
(Address) (City) (ZIP)

Mail *(if different)*: _____
(Address) (City) (ZIP)

Telephone: _____
(Home) (Work) (Message)

E-mail address _____

In what language do you prefer to communicate: English Spanish Other _____

Family Size and Income

Head Start of Lane County provides services to families: (1) with a family income at or below the Federal poverty guidelines; (2) who are receiving certain forms of public assistance; (3) who are applying on behalf of a foster child; (4) who are currently homeless. Head Start of Lane County may also serve a limited number of families with special needs who would not otherwise qualify for the program.

Family Size

In order to determine if your family income is at or below the Federal poverty guidelines, we must know how many people are living in your household, as well as your family income. For our purposes, a family is "... all persons living in the same household who are (1) supported by the income of the parent(s) or guardian(s) of the child enrolling in the program, and (2) related to the parent(s) or guardian(s) by blood, marriage, or adoption."

Please list all people in the household (including the child being applied for) who are supported by the income listed below. *(If you need more room, use another sheet of paper.)*

	Name <i>(First, Middle, Last)</i>	Relationship to Child	Date of Birth
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____

Automatic Eligibility

If you answer "Yes" to any of the following questions you are automatically income eligible for Head Start services. You will be asked to provide verification(s).

- Is your family **currently** receiving TANF benefits? Yes No
 - *Food Stamps, OHP Medical Card and Emergency Assistance are **NOT** considered for income eligibility.*
 - *TANF benefits include on-going TANF cash grant, Assessment Program, ERDC and Retention Activities and Services.*
- Are you or anyone in your family **currently** receiving Supplemental Security Income (SSI)? Yes No
- Is this application for a foster child placed with you through the State of Oregon? Yes No
- Is your family **currently** Homeless? *(living temporarily in shelters, hotels, or vehicles; or moving frequently between the homes of relatives and friends)* Yes No

Family Income

Income *(see definition below)* must include the total income of all members of the family listed above for either the past twelve months or for the previous calendar year, whichever more accurately reflects your family's current situation.

I HAVE ENCLOSED ONE OF THE FOLLOWING REQUIRED DOCUMENTS FOR INCOME VERIFICATION

- | | |
|--|---|
| <input type="checkbox"/> Pay Stubs (12 months) | <input type="checkbox"/> Individual Income Tax form 1040 <i>(expanded 1040)</i> |
| <input type="checkbox"/> W-2 Forms | <input type="checkbox"/> Written Statement From Employer / Pay Envelopes |

I HAVE ENCLOSED ONE OF THE FOLLOWING ADDITIONAL TYPES OF INCOME VERIFICATION

- | | |
|---|---|
| <input type="checkbox"/> Unemployment Information | <input type="checkbox"/> Child Support Information |
| <input type="checkbox"/> Social Security Benefits | <input type="checkbox"/> Financial Aid Award Letter |

HEAD START PROGRAM DEFINITION OF INCOME: Income means total cash receipts before taxes from all sources, with certain exceptions. Income includes: (1) money, wages or salary before deductions; (2) net income from non-farm or farm self-employment; (3) social security or railroad retirement; (4) unemployment compensation, strike benefits, workers' compensation, veterans benefits, or public assistance; (5) training stipends; (6) alimony, child support, military family allotments, other regular support from absent family member or someone not living in the household; (7) private pensions, government pensions including military retirement, insurance or annuity payments; (8) college scholarships, grants, fellowships, assistantships; (9) dividends, interest, net rental income, net royalties, receipts from estates or trusts; (10) net gambling or lottery winnings.

Other Assistance

Are you currently receiving assistance from any other agency? *(please check all that apply)*

Energy Assistance Food Stamps Subsidized Housing (Low-income; Section 8)

Is your child currently receiving medical or dental coverage through Oregon Health Plan (OHP)? Yes No

Priority

The following information will be used to prioritize your placement on the waiting list.

Please check all that apply.

DIAGNOSED MEDICAL OR BIOLOGICAL ISSUES

Please indicate any diagnosed medical or biological issues currently affecting your child.

- | | |
|---|---|
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Heart condition |
| <input type="checkbox"/> Asthma <i>(requiring medication)</i> | <input type="checkbox"/> Seizure disorder <i>(requiring medication)</i> |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Traumatic brain injury |
| <input type="checkbox"/> Eczema <i>(requiring medication)</i> | <input type="checkbox"/> Visual impairment |
| <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Other |
-

IDENTIFIED DISABILITIES

To provide the best placement for your child, please indicate any disabilities that have been diagnosed for which your child is receiving Early Childhood Special Education Services.

- | | |
|---|--|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Developmental delay |
| <input type="checkbox"/> Communication disorder | <input type="checkbox"/> Orthopedic impairment |

■ **Signature required** to exchange information with Early Childhood CARES _____

FAMILY CIRCUMSTANCES

Please indicate any issues which have occurred to your child's immediate family.

WITHIN THE LAST 2 YEARS (24 months)

- Child abuse or neglect
- Death in the family
- Divorce / Family Breakup
- Domestic violence
- Drug or alcohol abuse
- Parent or guardian in jail / incarceration
- Migrant Worker
- Homelessness *(includes families living temporarily in shelters, hotels, or vehicles; or moving frequently between the homes of relatives and friends)*

CURRENTLY

- Parent or guardian needs an Interpreter
 - Child is in foster care, and was placed with you by the State of Oregon
 - Child is not in foster care, but is not living with a biological or adoptive parent
 - Only one adult lives in the home
 - Military deployment
 - Parent or guardian is receiving disability payments *(please provide proof)*
 - Other
-

SPECIAL CIRCUMSTANCES

If you would like to be considered for Head Start even though you may not otherwise qualify, please describe the special challenges and circumstances of your family.

Program Models

Please review the program models below and indicate which would best meet your family's needs.

EARLY HEAD START MODEL – for ages 0-3 years

Are you applying for Early Head Start?..... Yes No

HEAD START MODELS – for ages 3-5 years

• Full-Day Option

Are you applying for Full Day?..... Yes No

- Designed for working parents and students who qualify and need childcare services
- Home visits throughout the year
- Typically open Monday–Friday 7:30-5:30

Are you working? Yes... No Do you have employment-related day care (ERDC)? Yes No

Are you going to school? Yes... No Do you receive financial aid for school? Yes No

Are you in the JOBS Program? Yes No

Do you need childcare for more than 3½ hours a day? Yes No

If you answered “Yes” to any of the above, you may be eligible for Head Start services at a Full Day Site or Community Childcare Center.

• Extended Day Option

Are you applying for Extended Day?.... Yes No

- Provides a preschool classroom experience
- 5 days a week for 6 hours a day

• Part-Day Option

Are you applying for Part Day? Yes No

- **PART DAY:** 3½ hour days, 4 days a week, AM or PM
- Home visits throughout the year

• We offer an in-person interview to determine your family’s eligibility.

- This would be a burden. *I understand this will **not** have a negative effect on my application.*
- Why? Transportation Issues Childcare issues Scheduling issues

Affirmation

★ Under penalty of perjury, I affirm that I am the parent or legal guardian of the child applying for Head Start, and that, to the best of my knowledge, all of the information that I have provided is complete and correct. **I understand that if I deliberately commit fraud by misrepresenting my family circumstances, my family will not be eligible for further services.**

★ I authorize Head Start to verify income, circumstances and proof of birth with a third party (DHS; employer, Oregon Immunization Alert, etc.), if necessary.

★ I authorize Head Start to share my enrollment information with the Preschool Promise Program. Yes No

Parent or Guardian Signature _____

Date Signed _____

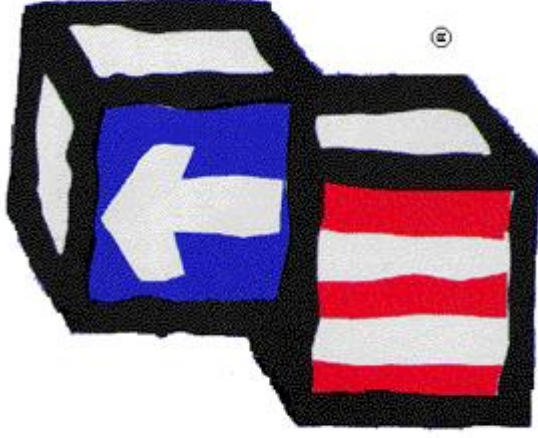
Head Start of Lane County does not discriminate against children or families on the basis of race, color, national origin, gender, religion, age, disability, political beliefs, sexual orientation, and marital or family status.

For Office Use Only		
	Staff Signature	Date
Date received: _____		
WebCAF #: _____		

Head Start of Lane County
221 B Street
Springfield OR 97477-4522

541-747-2425 • Fax: 541-747-6648

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221 B Street
Springfield OR 97477-4522

TO:

**Serving Children and Families
In Lane County**

"Ensuring that our youngest children
have a solid foundation for life."

Head Start of Lane County

Head Start and Early Head Start models provide comprehensive services for pregnant mothers, and families with infants, toddlers and preschool age children.

Early Head Start

If you have a child 0-36 months (has **not** turned 3 years of age by September 1st of the current enrollment year) you may qualify for one of the following parts of our **Early Head Start** model which operates year round (*12 months*):

- **Home Base Option**

Consists of weekly home visits to you and your child, play groups twice a month where you and your child interact with other parents and children in a classroom environment and Parent Groups. Childcare and snacks are provided for all groups.

- **Combination Option**

Children attend a classroom environment two days a week. Once a month parents and children have 'play time' in the classroom environment. Childcare and snacks are provided for 'play time'. Parents will also receive home visits.

- **Prenatal Option**

This option consists of home visits during your pregnancy to provide education and support. Once the baby is born she/he is automatically enrolled in to one of the options listed above.

Head Start

If you have a child who is 3 or 4 years of age by September 1st of the current enrollment year you may qualify for one of the following parts of our **Head Start** model:

- **Part Day Option (*9 months*)**

Operates 4 days a week for 3½ hour sessions AM or PM. The focus of this option is kindergarten readiness. Families also receive home visits and parent/teacher conferences. This option operates Mid-September through June.

- **Extended Day Option (*10 months*)**

Serves children 3-5 years of age. Children attend a classroom setting 5 days a week for 6 hours. This option operates from the beginning of September through June.

- **Full Day Option (*12 months*)**

Serves working or student families who need full day childcare. This option operates Monday through Friday, year round. Families also participate in home visits and parent/teacher conferences.

Please fill out this application completely. It contains important information that is used to determine your child's eligibility for Head Start and Early Head Start services. **IF YOU NEED HELP IN COMPLETING THE APPLICATION, OR HAVE ANY QUESTIONS, PLEASE CALL US AT (541) 747-2425.**

APPLICATION INSTRUCTIONS

Please fill out this application completely. It contains important information that is used to determine your child's eligibility for Head Start services. **IF YOU NEED HELP IN COMPLETING THE APPLICATION, OR HAVE ANY QUESTIONS, PLEASE CALL US AT (541) 747-2425.**

THE FOLLOWING INFORMATION MAY BE HELPFUL AS YOU ARE COMPLETING THE APPLICATION.

- **General Information** (*page one*): We must be able to reach you in order to enroll your child. If you move or change your phone number after completing this application, it is your responsibility to notify Head Start. Only a pregnant mother, parent or legal guardian may sign this application. You must provide proof of your child's date of birth with one of the following types of documents: Birth Certificate, hospital documentation, etc. You do not need to provide a Social Security Number (SSN) in order to be eligible for Head Start.
- **Income** (*page two*): If your family is a current recipient of TANF benefits from DHS, is receiving Supplemental Security Income (SSI), or is providing foster care for the child you are applying for, you automatically qualify for Head Start. You do not need to provide proof of income, but you must provide documentation that your family is currently receiving TANF, SSI or providing care for a foster child. If you are currently homeless, you are automatically eligible for Head Start and do not need to provide documentation of income.
- **Priority** (*page three*): Please fill out this page carefully – the information you provide in this section will help us prioritize your child's placement on the waiting list.
- **Signature** (*page four*): This affirmation must be signed and dated.

Once you have completed the application, please provide proof of your child's date of birth and proof of your family income and mail or bring your application to:

**Head Start of Lane County
221 B Street
Springfield, OR 97477-4522**

WHAT HAPPENS NEXT?

You will be contacted, either by phone or by mail, regarding the status of your application.