Community Services Office
BREAKING BARRIERS. CHANGING LIVES.

Head Start/Early Head Start Application

Head Start/Early Head Start/Early Head Start Child Care Partnerships

If you need any assistance completing this application, please contact us. We will gladly help you.

*****AN INCOMPLETE APPLICATION MAY DELAY YOUR CHILD'S ENROLLMENT*****

The enrollment process of your child is not complete without all the information listed below:

_____ Application - Completed, signed, printed name, and dated
_____ Immunization or Shot record
_____ Dental Screening
_____ Child's Medicaid or insurance card (if applicable)
_____ Birth Certificate (or other official verification of child's age)
_____ Family proof of income: (one of the following) Income Tax, W-2, Check Stubs, Verification from Employer, Self-Employment-1040 schedule C, Unemployment Benefits/Workers Compensation, SS or SSI, VA Benefits/Pensions, Retirement Income, Tea/Work Pays, Royalties, Work Study Income, Child Support Proof, Contributions, Statement, etc.
_____ Physical with the Lead & Hematocrit or Hemoglobin level listed
_____ Certified IEP (For those with suspected or diagnosed disabilities)
_____ Doctor's Documentation of any diagnosed medical conditions such as, but not limited to; Asthma, Diabetes, Sickle Cell Anemia, etc., and any prescribed medications that would need to be administered during school hours.
_____ Photo ID, Driver's License, State ID, Federal ID, or Student ID, etc.

Early Head Start Child Care Partnership (EHSCCP) (age birth through 2) also requires the following:

______ Proof of Residence: (Utility Bill, State or Federal ID, Completed Current Lease Agreement, or Current Mortgage Payment that lists the address)
______ Child's Social Security Card
______ Proof of Alien status for any household member who is not a U.S. Citizen
______ DHS Voucher Application Parent Letter
______ Parent's Class Schedule (If Applicable)

Office Use Only
Circle One:

HS / EHS

1st Year

2nd Year

3rd Year

Mission Statement: The Community Services Office, in partnership with the community, will focus on strengthening the educational, social, and economic well-being of individuals and families as they move toward economic independence and self-sufficiency.

Eligibility – Children from birth to 5 are eligible for Head Start or Early Head Start. There is no cost to attend the Head Start/Early Head Start Program; however, transportation is not provided. The following are categorically eligible:

- Children with family incomes below the Federal Poverty Level
- Children of families eligible for Temporary Assistance for Needy Families (TANF)
- Children of families eligible for Supplemental Security Income (SSI)
- Children who are experiencing Homelessness
- Children in the Child Welfare System (Foster Care)

Recruitment– Head Start/Early Head Start families are recruited in the County area. It is advertised and applications are made available at various locations. If a parent or guardian wishes to enroll their child, they complete an application.

Selection– Upon receipt of an application, it is first checked for completion. If it is complete, the screening committee or ERSEA Coordinator screens the application for eligibility using a point system, which is based on the needs of the family. After review by the screening committee, all eligible applicants are either enrolled or placed on a waiting list and their parent/guardian is notified by letter or phone concerning the status of their application.

Enrollment – Applicants placed on the waiting list are enrolled, if possible, when a slot becomes available. Upon enrollment, an appointment time is set for the family to complete orientation. During orientation, they complete more paper work and speak to the content staff.

Attendance – The Head Start children are expected to come to class the on first day of school and Early Head Start children upon eligibility.

Criteria for Selection

- Head Start/Early Head Start will place families that are at or under the income guideline (100% or below) as soon as spaces become available using a point system by which the families with the most points are placed first.
- Eligible families that are between 100% and 130% on the income guideline will be placed second (35% of slots may be in this category)
- If slots are still available, eligible families who are over 130% will be added last (10% of slots may be in this category)
- In the event that several families have the same number of points, the family who enrolled first will be placed first.
- At least 10% of our slots will be used for children with disabilities.

Note: In order for you to receive notification, it is important that we maintain a current address and phone number for your family. Therefore, please notify us if any changes are made.

DHS Licensing Sheet

The Arkansas Department of Human Services, Division of Child Care and Early Childhood Education, licenses the Community Services Office, Head Start/Early Head Start Program Centers.

Licensed and registered childcare providers have minimum licensing requirements for operating childcare centers.

Timeouts will not be used for children under the age of two.

At regular intervals, a licensing agent monitors all centers for compliance with minimum licensing requirements. Any findings are listed and corrections are required. These findings are available for parents to review upon request.

Regarding child abuse, neglect, or maltreatment, children enrolled in CSO Head Start/Early Head Start Centers may be subject to interviews by licensing staff, child maltreatment investigators, or law enforcement officials for investigative purposes.

Within 15 days of enrollment of a child, a licensed childcare facility shall verify that the child has age-appropriate immunizations as required by the Arkansas Department of Health and Human Services, or the child cannot remain in care. (Arkansas Code 20-78-206 as amended by Act 870 of 1997 – a current immunization schedule is provided as an insert in this publication.)

All information given to Head Start/Early Head Start is kept in the child's folder in his/her classroom under lock. The only people with access to this information are Head Start/Early Head Start staff, persons of interest (such as Dawson, First Connections, etc.), and the child's legal guardian.

A calendar of Kindergarten Readiness Skills, prepared by the Arkansas Department of Education, has been supplied to each parent in the Head Start/Early Head Start Program. School Readiness Goals for Infants and Toddlers has been supplied to each parent in the Early Head Start Program.

I have received a copy of *"You Can Prevent Shaken Baby Syndrome."*

Children shall be protected from overexposure to the sun. Sunscreen shall be used if needed and directed by the parent.

I give permission for my child to have sunscreen and insect repellant administered to him/her as needed.

Yes _____ No _____

Child's name ____

Parent/Legal Guardian's Signature ____

Parent/Legal Guardian's Printed Name____

Date of Application _____/_____/____

Child's Personal Data Sheet

Date Applied ____/____/_____ School District in which the child currently resides___________________________________

Desired Center/Classroom – 1st Choice _______________________________ 2nd Choice ______________________________

Child's Information:

Child's Name ____________________________ ___________________________ ____________________________
First Middle Last

Age as of August 1, this year ______ Date of birth: _____/_____/______ SSN #: ______-_____-________

Language(s) spoken: English____, Spanish____, Other: __________________ Gender: Male ____ Female____

Race: (Circle one or any that apply to you)

White	Black / African American	Hispanic / Latino
American Indian	Pacific Islander / Native Hawaiian	Bi-racial
Asian	Other____	

Medicaid #_____________________________

(AR Kids ___ AR kids First ___, A ___, B ___, # _________________________)

Private Insurance # ____________________________ ID/policy # _______________________________

Military Health (Tri-Care or CHAMPUS) ____

Non-Insured at this time of enrollment ____

Did Head Start/ Early Head Start assist you in filling out an application for AR Kids Insurance? Yes____ No____

Medical Information:

Dental Examination:

An age-appropriate dental exam by a dentist is required. If you do not have a copy of a current exam for your child, you will be asked to take your child to the dentist to obtain one. This should be completed before your child is enrolled.

Is a copy of child's dental exam included with this application? Yes _____ No_____

Dentist/Clinic Name ____

Business Address: ______________________________ City ____________________ State _____ Zip __________

Phone # ______ /______ /_________ Fax #______ /______ /_________

Date of child's last dental exam: ______/______ /________ None _____

My child has no dentist at this time: _______

Physical Examination:

A physical examination by a physician is required. This exam must include age-appropriate Lead and Hemoglobin/ Hematocrit (blood work) tests. A TB assessment may be conducted if this child is considered to be at risk. If you do not have a copy of a current physical exam for your child, you will be asked to take your child to the doctor to obtain one. This should be completed before your child is enrolled.

Is a copy of child's physical exam included with this application? Yes _____ No_____

Doctor/Clinic Name ____

Business Address: ________________________________ City ___________________ State ______ Zip ____________

Phone # _______-_______-__________ Fax #_______-_______-__________

Date of child's last physical examination: _____/_____/_____ My child has no doctor at this time: _______

Immunization:

Before your child can be enrolled into Head Start/Early Head Start, we must be provided an authorized record of up-to-date immunizations or documentation of a religious or medical exemption from the Arkansas Dept. of Health and Human services.

Child's shot record verified by:

Health Dept. Record ______Physician's Record ______ Other ____________________________________

Disability/Disease History:

Circle any your child currently has or has had in the past:

Asthma	Autism	Anemia
Chicken Pox	Diabetes	Drugs
Ear Infections (frequent)	Emotional/Behavioral	German Measles
Heart Defect	Learning Disability	Measles
Mental Retardation	Mumps	Orthopedic Impairment
Obesity (overweight)	Speech/Language	Throat Infections (frequent)
Tuberculosis	Visual Impairment	Whooping Cough

Has your child been diagnosed by a professional for the items circled above? Yes _____ No _____

Does your child have an Individualized Education Plan (IEP or IFSP)? Yes _____ No _____

Is your child currently receiving services from another agency? Yes _____ No _____

If yes, please list agency: ____

Does your child have any food allergies? Yes _____ No _____ When was your child's last attack? ______________________

If so, to what? ____

Other special health needs or comments: ____

Birth Information:

Was child premature? Yes _____ No _____

While in the hospital, did the child experience any complications? Yes _____ No _____

If yes, explain: ____

____

Other useful information ____

Social/Emotional Development:

Physical or emotional problems the child might have: ____

Child's special food needs: Formula _____ Diabetic Diet _____ Allergies____________________________

Special concerns: Medications ______ Seizures ________ Fainting Spells _______ Eating ______ Bed Wetting ________

Is child toilet trained? _____ Words used in toileting ______________________________________

Requires help: Dressing ________Undressing _______ Toileting ________ Eating _________ Washing Hands _____________

Favorite: Games __________________________ Toys _________________________ Foods ____________________________

Type of Childcare used before ____

Does your child have trouble with any of the following? (Circle any that apply to your child.)

getting along with other children their same age	aggressive behavior
getting along with other family members	extreme shyness
problems separating from parents/guardians	severe fears
problems sleeping	temper tantrums
child abuse or neglect	death of immediate family member

Is your child receiving mental health services? Yes ______ No _____

Do you have any other concerns about your child or his/her behaviors? Yes _______ No _______

If yes, what concerns do you have?

____

____

Parental Information:

In order for you to be classified as a working parent, you must provide proof of work or school attendance.

Parent/Guardian #1: Working ____ Non-Working ____ Parent/Guardian #2: Working ____ Non-Working ____

Check one: Single ______ Married ______ Widowed ______ Divorced _____ Separated ________

Unmarried Living Together _______ Other ____

Incarcerated: Parent 1? Yes _______ No _______ Parent 2? Yes _________ No _________

In Drug or Alcohol Rehab: Parent 1? Yes _______ No _______ Parent 2? Yes _________ No _________

Is child living with relatives/friends due to parent incarceration or abandonment? Yes ______ No ______

Is mother living with enrolling child's father? Yes _______ No _______

Name of person enrolling child ______________________________ Relationship to child _____________________

If not the child's biological parent, specify your relationship to the child. ___________________________________

Who is legally responsible for child? Parent/Guardian 1 ______ Parent/Guardian 2 ______ Both Parents _______ Foster Care _________ Grandparent(s) _______ Other ____

First Parent/Guardian's Information:

Which one are you? Parent _______ Stepparent _____ Grandparent ______ Foster Parent ______ Other ______________

Name ____DOB ____/____/____ Age _______ Race _____

Parent's place of employment ____ Department _________________________

Work Hours: from ________ to________

Are you employed full time? Yes _____ No _____ Part time? Yes _____ No_____

Retired? Yes _____ No_____ Veteran? Yes _____ No _____ Disabled? Yes _____ No_____

Parent's highest-grade completed _______ Did you graduate? Yes _____ No _____ GED? Yes ______ No ______

Living Address: ___________________________________ Apt. #_____ City ___________________ State _____ Zip _______

Is your current address a temporary living arrangement? Yes _____ No _____

Mailing Address: _________________________________Apt. #_____ City _____________________ State ____ Zip________

Home Phone # ________-_______-__________ Cell Phone # ________-________-___________

Work Phone # ________-_______-__________ Message Phone # ________-________-___________

Parent in School/Training: Yes ________ No________ Student Status: Full Time ________ Part Time ________

School's Name ____ Course of Study __________________________________

Do you have a Degree or Certificate? Yes ______ No ______ In what field? ____

Email Address: ____

Are you pregnant? Yes _______ No _______ Expected Due Date: ________/________/_________

Second Parent/Guardian's Information:

Which one are you? Parent______ Stepparent______ Grandparent______ Foster Parent ______ Other ________________

Name ____ DOB _____/_____/_____ Age ______Race ________

Parent's place of employment ______________________________________ Department ___________________________

Work Hours: from __________ to__________

Are you employed full time? Yes ______ No ______ Part time? Yes ______ No______

Retired? Yes _____ No_____ Veteran? Yes _____ No _____ Disabled? Yes ______ No______

Parent's highest-grade completed _______ Did you graduate? Yes _____ No _____ GED? Yes _____ No _____

Living Address: ______________________________ Apt. #_____ City _____________________ State ______ Zip ________

Is your current address a temporary living arrangement? Yes _____ No _____

Mailing Address: ____________________________ Apt. #_____ City _____________________ State ______ Zip_________

Home Phone # ______-______-_________ Cell Phone # ______-______-_________

Work Phone # ______-______-_________ Message Phone # ______-______-_________

Parent in School/Training: Yes _______ No_______ Student Status: Full Time _______ Part Time _______

School's Name ______________________________________ Course of Study _____________________________________

Do you have a Degree or Certificate? Yes ______ No ______ In what field? _______________________________________

Email Address: ____

Are you pregnant? Yes _______ No _______ Expected Due Date: ________/________/_________

Living Situation:

How long has family lived in this county? ________________________, At your present address? ________________

Do you plan to relocate from this county? Yes _______ No _______ If yes, when: ________________________________

Who, living in the home, does your income support? (List below)

	Name	Birthdate			Name	Birthdate
1	Parent 1:			6	Child:	
2	Parent 2:			7	Child:	
3	Enrolling Child:			8	Child:	
4	Child:			9	Child:	
5	Child:			10	Child:	

Total number of people supported by Parent's Income combined: __________

If Single: Total number of people supported by Legal Guardian's Income: ___________

Presently, where is this child living? ____

Do you consider yourself homeless/Moving place to place? Yes ______ No ______

If yes, where are you sleeping? (Check one)

In a shelter_______, In a motel/hotel________, in a car________, campsite_________,

With more than one family, in a house or apartment for economic reasons_________

With friends or family members (other than parent/legal guardian) for economic reasons _________

None of the above________ (Question addresses the McKinney-Vento Act)

Do you live with someone? Yes _______ No _______ Is someone living with you? Yes _______ No _______

List other persons presiding in the home not listed in 1-8 above:			
	Name	Birthdate	Relationship to Child
1			
2			
3			
4			
5			
6			

Total numbers of persons living in this household: __________

Family Assistance Information:

How did you find out about the Head Start/Early Head Start Program? Newspaper ________, TV/Cablecast ________, Flyer/Pamphlet ________, Word of Mouth ________, Friends ________, Family ______, DHS ______, WIC _______, HUD ______, Bench Ad. ______ Housing Authority ______, Staff _______, Health Dept. _______, Another Outside Agency ____ Other ____
Do you receive assistance? Yes_______ No _______ (Check all received below.) HUD _______ SNAP (Food Stamps) _______ TANF/TEA ________ WIC ________ Do you receive Voucher Subsidies for Childcare? Yes ______ No ______
Do you receive any of the following? VA ______ SSI ______ SS ______ If yes, who is it for? Parent 1 ______ Parent 2 ______ Both Parents ______ Sibling ______ Enrolling Child _______ (Please supply documentation if for parent or enrolling child.)
Do you receive Child Support? Yes _____ No _____ If yes, how often do you receive it? ______________________ Who is it for? _____________________________________ Is it for the child you are enrolling? Yes ______ No ______ (If yes, please supply documentation.)
Were you unemployed last year? Yes ______ No ______ If yes, for how long? _____________________________ Did you receive Unemployment pay? Yes _____ No _____ If yes, how much did you receive? _______________ (If yes, please supply documentation.)

Signature:

Please read & sign:

I, ____, (Legal Guardian) do hereby give my consent to the Director of Community Services Office Head Start/Early Head Start, or his/her duly appointed representative, for said child, ____, to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parent/guardian cannot be reached. Consent is also given for the Director or his duly appointed representative to transport said child for emergency medical treatment if the parent cannot be reached. I, the parent/guardian of this child, understand that I may ask for a conference with the caregiver(s) as needed.

Signed ____ Date ____/____/_____

Witness _______________________________________ Date ____/____/______

Additional Comments:

____

____

____

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Eligibility Verification

Child's Name: ____

Child's Date of Birth: _____/_____/_____ Is this child eligible to participate in HS/EHS? Yes _____ No _____

Re-enrollee? Yes _____ No _____ (Do not change eligibility unless over-income is now income eligible.)

Interview: In Person _____ By Phone _____ Date/Time of Interview _____/_____/_____, _____:_____ a.m./p.m.

- Check the applicable category of eligibility for this child:
  - _____ Income below federal poverty guidelines
  - _____ Income between 100% and 130% of federal poverty guidelines (35%, 70 slots only)
  - _____ Over income, above 130% of the federal poverty guidelines (10%, 20 slots only)
  - _____ Public Assistance (TANF)
  - _____ SSI
  - _____ Homeless
  - _____ Foster Care

- What documentation was used to determine applicable category of eligibility?
  - _____ Income Tax Form 1040
  - _____ W-2
  - _____ TANF documentation
  - _____ Pay Stub or Pay Envelopes
  - _____ Unemployment
  - _____ Written Statements from employers
  - _____ Foster Care reimbursement
  - _____ SSI documentation
  - _____ Documentation of No Income (If this item is checked, complete box below.)
  - _____ Other (If other, please explain.) ____

- No income documentation (Fill out interview questions below only if family states that they have **NO** income.)
  How is family managing to secure:
  - Shelter ____
  - Food ____
  - Personal Necessities ____
  - Other ____

Parent/Guardian Signature ___________________________ Staff Signature: ___________________________

ERSEA Coordinator Signature: ___________________________ Date of eligibility verification: _____/_____/_____

(Application Revised 3/31/21)