



Thank you for your interest in Early Head Start.

Summit County Early Head Start will serve 24 children ages 0-3 as well as pregnant women. Early Head Start works in partnership with the families and the community in providing home visitation, childcare, education, health services for children, as well as self-sufficiency services to their families. Summit County Head Start is a partnership between Summit County Government, Summit School District, Early Childhood Options, and the Family & Intercultural Resource Center and works collaboratively with licensed center-based and family childcares.

As part of the process of recruiting eligible children and their families for Early Head Start, the following information and forms are required to be complete in order to begin your eligibility process.

- Early Head Start Application Form
- Interagency Release Form
- Complete Income Information providing a clear picture of the last **12 months**
 - Income Verification Application
 - Employment Verification & Income Information such as:
 - Individual Income Tax Form 1040
 - W-2 forms
 - Pay stubs with Gross Year to Date Totals (GYTD) or pay envelopes for last 12 months
- Birth Certificate
- Copy of Social Security Card (for those born in the U.S.)
- Immunization Record
- Health Status Form

Head Start accepts applications year round; full-day/full-year programs are available for families with working parents or parents who are in school or job training.

Please send the needed information to our office as soon as possible. We must have all information for your initial interview. If you have any questions or would like more information, please feel free to contact:

Sheila Groneman
Director
970-513-1170 ext. 310

Family Engagement Specialist
Jason Read
970-513-1170 x 311

Emily Schwier
Program Assistant
970-513-1170 ext. 308

Summit County Head Start Program
PO Box 497 Dillon, CO 80435
330 Fiedler Ave, Suite 209
Fax 468-7923



Interagency Release

**Summit County
Head Start
PO Box 497
Dillon, CO 80435
970-513-1170 x. 311**

I give the Head Start program and the following agencies permission to exchange information which may be pertinent to the provision of services to myself and my family. This authorization shall continue force until revoked by me in writing.

A copy or fax of this authorization shall serve in its stead, and includes permission to copy, release or discuss information with the purpose of facilitating interagency coordination in providing services to myself and my family

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Check all that apply

- Summit County Head Start (SCHS)
- Early Head Start Childcare Program Options at Summit County Preschool and Licensed Family Childcares
 - The following specified programs offered by our partner Summit County Public Health and Nursing –
 - WIC, Women, Infants and Children
 - Public Health Prenatal Program
 - The following specified programs offered by our partner Family and Intercultural Resource Center -
 - Families United Program
 - General Assistance Program
 - The following specified programs offered by our partner Summit County Department of Social Services -
 - CCCAP – Colorado Child Care Assistance Program
 - Early Intervention Colorado
 - Part C
- Colorado Child Health Plan (CHP+) _____
- Mental Health Provider _____
- Dental Care Provider _____
- Summit County Community Care Clinic _____
- Others: _____

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Child's Name _____

Staff Signature _____
† (I have explained the purpose of this form to the person who signed it)

Print Name _____

Parent Signature _____

Date _____



EARLY HEAD START PROGRAM APPLICATION

(All information will be kept confidential and is only used to determine appropriate placement)

Child's Name: _____ Date of Birth: _____

First Middle Last

Gender: _____ Home/Cell Phone (where we can leave msg.): _____

Mailing Address: _____ City: _____ Zip: _____

Physical Address _____ City _____

Home Based Program Options:

Weekly Home Visitation with an
Early Head Start Home Visitor

Childcare Program Options:

(Space is limited)

Full-Day Center-based Childcare
 Full-Day Family Childcare Home

Check One: Two parent household Single parent Household Foster Care Family

Mother/Guardian (Circle One) Name _____ D.O.B. _____

Living with Child? **No or Yes** Mailing address if different from child: _____

Employed? **No or Yes** (Circle One) Place of Employment: _____

Work Phone: _____ Income: _____ Gross per month.

Are you pregnant? **No or Yes** When is your due date? _____ Is this your first child? **No or Yes**

Father/Guardian (Circle One) Name: _____ D.O.B. _____

Living with Child? **No or Yes** Mailing address if different from child: _____

Employed? **No or Yes** (Circle One) Place of Employment: _____

Work Phone: _____ Income: _____ Gross per month.

FAMILY INFORMATION: NUMBER OF SIBLINGS **LIVING WITH THE CHILD:** _____

Name _____ Gender _____ Birthdate _____ Relationship to child _____

Name _____ Gender _____ Birthdate _____ Relationship to child _____

Name _____ Gender _____ Birthdate _____ Relationship to child _____

Name _____ Gender _____ Birthdate _____ Relationship to child _____

To the best of my knowledge, the information given on this form is true and accurate. I also understand that failure to respond to all questions truthfully may negatively impact my child's placement. Completion of this application does not guarantee enrollment in any program.

Parent Signature

Date



1. Please circle if a child's family is currently living in any of the following circumstances due to economic hardship:

Hotel/motel __ **Shelter** _ **Transitional housing** _ **Campground/RV Lot/Car** ____ **With others** ____

2. Are there circumstances in the child's home that would cause the child to be exposed to abuse or domestic violence? **No** **Yes** **If yes, please explain:** _____

3. Are there circumstances that would cause the child to be exposed to the abuse of drugs or alcohol in the home? **No** **Yes** **If yes, please explain:** _____

4. Was either of the child's parents less than 18 years of age and unmarried when the child was born?
No **Yes**

5. Have both parents or guardians successfully completed a high school education or its equivalent?
Mother - **No** **Yes** Father - **No** **Yes**

6. How many times has your family relocated to a new residence in the past 2 years? **1** **2** **3** **or more**

7. Do you or anyone else believe the child has difficulty using his/her native language to communicate needs?
No **Yes** **If yes, please explain:** _____

8. Does the child speak some English? **No** **Yes**

9. Is your family receiving any local, county or state services? **No** **Yes**

If yes, Please circle which one(s): **WIC** **TNF** **CHILD PROTECTION** **FOSTER CARE**
SOCIAL SERVICES **CCAP** **FAMILIES UNITED** **HEADSTART**

(If accepted into the program, verification of program services will need to be provided).

10. What health insurance does the mother/child have? **MEDICAID** **CHP+** **PRIVATE INSURANCE**

11. If the child has a sibling in school, does the child currently receive free or reduced lunch? **No** **Yes**

12. Do you or anyone else have concerns about your child's behavior? **No** **Yes**

If yes, please explain _____

13. Do you or anyone else have health concerns? **No** **Yes**

If yes, please explain _____

The information given on this form is true and accurate. I give all agencies marked on the attached interagency release form permission to exchange this application information for the provision of services to my child and my family. This authorization shall continue until revoked by me in writing. Completion of this application does not guarantee enrollment in any program.

Parent Signature

Date



INCOME VERIFICATION APPLICATION

The family income for the last year must be verified by the Head Start program before determining that a child is eligible to participate in the program.

Income Includes: Money wages or salary before deductions, Child support, Public Assistance (TANF), Unemployment Payments, Social Security Payments, Alimony, Emergency Assistance money payments, training Stipend, Military family allotments, College or University Scholarships, grants & fellowships, Dividends & Interest.

Parent(s) and/or Gurardians, please list ALL jobs for the last 12 months :

Name	Relationship to Child
Employer#1 _____	Address _____
Dollars/hour \$ _____	Hours/week _____ Days/week _____
Start Date _____	End Date _____
Employer#2 _____	Address _____
Dollars/hour \$ _____	Hours/week _____ Days/week _____
Start Date _____	End Date _____

Name	Relationship to Child
Employer#1 _____	Address _____
Dollars/hour \$ _____	Hours/week _____ Days/week _____
Start Date _____	End Date _____
Employer#2 _____	Address _____
Dollars/hour \$ _____	Hours/week _____ Days/week _____
Start Date _____	End Date _____

VERY IMPORTANT:

You must provide one or more of the following documents from **ALL** working members of the family who help support your child:

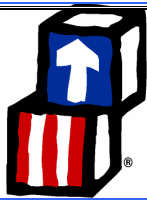
- Individual Income Tax Form 1040
- W-2 forms
- Current pay stubs with Gross Year to Date Totals (GYTD) or pay envelopes for 12 months
- Written statements from employers (Employment Verification & Income Information letter included)
- Documentation showing current status as recipients of public assistance.

The period of time to be considered for eligibility is the twelve (12) months immediately preceding the month in which application or reapplication for enrollment of a child in a Head Start program is made, or for the calendar year immediately preceding the calendar year in which the application or reapplication is made, whichever more accurately reflects the family's current needs.

I hereby certify that the above information is true and complete.

Employed Parent(s) Signature

Date



Summit County
Early/Head Start

PO Box 497, Dillon, CO 80435
970-513-1170 x311
Fax: 970-468-7923

Tráelo este formulario al médico para completar
CHILD'S HEALTH STATUS FORM

Dear Physician:

The completion of this statement is necessary for this child to be enrolled in Head Start.

Today's Date _____

Child's Name _____ Sex _____ DOB _____

Address _____

PO Box

Town

Physical Address

Mother or Guardian's Name _____

Father or Guardian's Name _____

Date of most recent or current health exam _____

*****Required by Head Start at ages 12 months and ages 3 and 4**

*****HEMATOCRIT:** _____

*****Lead Screening/Assessment Date** _____ **Result** _____

Height _____ **Weight** _____ (all children)

If Tuberculin test give; Date _____ Result _____

If Chest X-ray given; Date _____ Result _____

Surgery, Accidents, Illnesses, Chronic or Handicap Problems: _____

Physical findings (include vision and hearing): _____

Need for medication or special diets? _____

Comments and recommendations to program personnel: _____

Physician's Name _____

Physician's Signature _____ Date _____

Physician's Telephone Number _____

Physician's Address _____

PO Box

Town

Zip

Please attach an actual copy of the physical exam
and current Immunization Record