

APPLICATION THANK YOU FOR YOUR INTEREST IN EARLY /HEAD START 0-5 2024-2025

Early Head Start and Head Start programs provide comprehensive family services for families with children ages prenatal to 5 years old. We work in partnership with the families and the community in providing comprehensive services, including:

- Health Support/ Mental Health Support
- Education Services
- Self-Sufficiency Development

We take pride in participating in an integrated program model within the school district preschools, and community-based center programs. We focus on the importance of child initiation, creative play, hands-on discovery, and continuous exposure to developmentally appropriate activities for each child. Available programming includes:

- Full day preschool for children ages 3-5
- Full year childcare/preschool for infants, toddlers, and preschoolers

As part of the process of recruiting eligible children and their families, the following information is required. Please complete and return the following to us:

- _____ Completed Application
- _____ Signed Interagency Release
- _____ Housing Questionnaire
- _____ Family Income Verification for the last 12 months (e.g., taxes, W-2, paystubs, employer letter verifying income, Head Start Form)
- _____ Residency Verification (e.g; Head Start Form, Lease, bill, bank statement)
- _____ Copy of Child's Birth Certificate
- _____ Copy of child's immunizations & General Health Appraisal Form
- _____ ASQ3 & ASQSE 2 Parent Questionnaires (Online)

Families who are applying for full year, full day childcare/preschool, we encourage you to also apply for the Care and Education Assistance Programs.

Tuition assistance:

- Colorado Childcare Assistance Program (CCCAP)
- Summit First Steps Ages 0-3
- Summit Pre-K Program (SPK)
- Universal Preschool (UPK)

PARENT/GUARDIAN ACKNOWLEDGMENT

I certify under penalty of perjury that the above information is true and correct to the best of my knowledge. I understand that providing false or distorted income information may result in my removal from the program. I understand that this application will not be complete until all required information is submitted, and it is



The Head Start 0-5 program is a partnership between

- Summit County Government.
- Summit School District.
- Early Childhood Options
- Clayton Early Learning
- Summit County Preschool.
- Lake Dillon Preschool.
- Wildflower Nature School.
- Carriage House Early Learning Center

We accept applications year-round, and always maintain a waitlist.

Dulce Hernandez
Eligibility and Enrollment
Coordinator
970-368-3120 *bilingual

After we receive your application, program eligibility will be determined based on your income or other qualifying factors.

Completing the application does not guarantee a place in the program.

The complete application package must be delivered to any of the following options:

Summit Head Start,
330 Fiedler Ave Suite #100, Dillon,
CO 80435
Email:
dulce@earlychildhoodoptions.org



Summit County Head Start Program 0-5

PO Box 3355/330 Fiedler Ave. Suite 100 Dillon, CO 80435

Service Preference (if applying for Early Head Start, ages 0-3):

- Lake Dillon Preschool Wildflower Center Summit County Preschool Carriage House

Preschool of preference (if applying for Head Start, ages 3 to 5)

- | | | |
|---|--|---|
| <input type="checkbox"/> Dillon Valley Elementary | <input type="checkbox"/> Lake Dillon Preschool | <input type="checkbox"/> Summit County Preschool |
| <input type="checkbox"/> Upper Blue Elementary | <input type="checkbox"/> Wildflower Center | <input type="checkbox"/> Carriage House Early Learning Center |
| <input type="checkbox"/> Silverthorne Elementary | | |

Applicant Child Information					
Child's Name	Middle name	Last Name	Date of Birth	Sex	Language spoken at home:
				<input type="checkbox"/> F <input type="checkbox"/> M	First: Second:
Citizenship Status: <input type="checkbox"/> Citizen <input type="checkbox"/> non-Citizen <input type="checkbox"/> Qualified Immigrant		Health Insurance:		Primary Medical Location Doctor/Clinic Name:	
Race: (Check what applies)				Dentist/Clinic Name:	
<input type="checkbox"/> American or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Multi Racial/Biracial <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other: _____		<input type="checkbox"/> Medicaid <input type="checkbox"/> CHP+ <input type="checkbox"/> Community Care Clinic Card <input type="checkbox"/> None <input type="checkbox"/> Private/Other: _____		Telephone:	
Hispanic/Latino: <input type="checkbox"/> Yes <input type="checkbox"/> No				Telephone:	

Additional Child Information:			
(please answer each question)			
Concern about your child's development	<input type="checkbox"/> Yes	<input type="checkbox"/> No	IEP (Individual Education Plan)
Others have concerns about my child's development.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	IFSP (Individual Family Service Plan)
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have documentation (diagnosed disability)
If yes, please explain:			Have a chronic medical condition.
			Have any allergies (including any food)
Are there any custody issues or restraining orders we need to be aware of? If yes, please explain and provide a copy of the legal orders:			<input type="checkbox"/> Yes <input type="checkbox"/> No
Household Type:	<input type="checkbox"/> Single Parent (Male) <input type="checkbox"/> Single Parent (Female) Date of Separation: _____ <input type="checkbox"/> Both Parents in Home <input type="checkbox"/> Foster <input type="checkbox"/> Multigenerational home <input type="checkbox"/> Temporary Family <input type="checkbox"/> Adults not related to children <input type="checkbox"/> Grandparents raising grandchildren <input type="checkbox"/> Other _____		
Has your child attended another childcare or preschool? No <input type="checkbox"/> Yes <input type="checkbox"/> What is the name of the school or childcare?			
Please write down other comments, concerns, or anything else that you think would help your application.			

2024-2025 Eligibility Application PC-Approved by PC 01.22.24

Please fill out this application completely.

All information is confidential and will only be shared to determine the appropriate position.

I am aware that failure to answer all questions truthfully may negatively impact acceptance into the program.

Completing an application does not guarantee enrollment in any program.

Summit County Head Start Program 0-5

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General Home Information

Do you live outside of Summit County? No Yes _____
 (County Name)

Family is new to the county: No Yes (Explain) _____
 (6 months or less living in the county)

Physical Address:		City:	Status: CO	Zip code:	
Mailing Address (Po Box)		City:	Status: CO	Zip code:	

Your Family Is Considered Homeless Yes No
 Homeless* (living with family or friends, in a shelter, car, motel, or hotel (due to financial situation)
Number of times you've moved house in the last year. _____
 *The term "homeless" means individuals who lack regular or adequate nighttime residence due to homelessness, economic hardship, or a similar reason.

Current state of the Home:	Current housing situation:
<input type="checkbox"/> Stable Housing <input type="checkbox"/> At Imminent Risk of Losing Housing <input type="checkbox"/> At Risk of Homelessness How Many Bedrooms is the Home: _____ Housing situation (more than 2 people per room) Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> Own <input type="checkbox"/> Rental (not subsidized ___ or ___ subsidized). <input type="checkbox"/> Living/Staying with Another Person, Friend, or Family Member <input type="checkbox"/> Emergency or Shelter _____ <input type="checkbox"/> Unintended place (no room, no kitchen, no uninhabitable place) <input type="checkbox"/> Substance Abuse Treatment Center/Detox Center

There are other programs or Benefit Assistance that your family is currently receiving

Medicaid _____ **Medicare** _____ **CHP+** _____ **Other** _____
 _____ SSI (Colorado Supplement to SSI), help for the disabled.
 _____ SNAP/EBT (Supplemental Nutrition Assistance Program).
 _____ TANF (Colorado Works) – which at the federal level is called Temporary Assistance for Needy Families.
 _____ LEAP (Energy Assistance for Low-Income Homes (Help Pay Heating Bill).
 _____ WIC- Women, Infants, Children _____ Foster Care/Adoption Allowance _____ Child Support/Alimona _____ Public Housing (Section 8)
 _____ FIRC _____ NFP -Nurse Family Partnership _____ SFOP- Strengthening Family
 _____ Advocates/Victims of Assault
 _____ Building Hope _____ Alma _____ SMART _____ ACCION Peer Support for Latino Men _____ Other (write it down):

Financial Assistance for Daycare or Preschool: _____ CCCAP- Child Care Program _____ Summit First Steps Ages 0-3 _____ SPK 3-5

Family circumstances within the household (check all that apply): _____ Not Applicable

- Family member other than the child with illness, therapy, or mental counseling _____
- Family member other than the child with medical issues _____
- Family member other than the child with disabilities _____
- Substance Abuse/Treatment _____ Violence Domestic _____ Abuse/Child _____ Neglect
- Loss of a family member due to death (within the past 12 months) _____
- Father was deported or incarcerated (within the last 12 months) _____
- Transport or auto _____ difficulties

Was the child you are applying for premature? No Yes, yes how many weeks? _____

Do you have internet access at home? Yes No

When the first child was born, were the parents under the age of 18 and unmarried? No Yes Father _____ Mother.

Alternate or Emergency Contact

Name and Last Name:	Phone Number:	Relationship with the Family:

Summit County Head Start Program 0-5

PO Box 3355/330 Fiedler Ave. Suite 100 Dillon, CO 80435

Adult Information #1					
Name	Initial	Last Name	Date of Birth	Sex	Language:
				M F	Primary: Secondary:
Do you reside with the applicant child?	<input type="checkbox"/> Yes <input type="checkbox"/> No (Please share your address if you are not living with the child)			English Skills:	<input type="checkbox"/> Nothing <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient
Relationship with the Child:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent/Guardian Relative <input type="checkbox"/> Other			Phone Number:	
Email:		How do you prefer to be contacted? Call <input type="checkbox"/> text <input type="checkbox"/> email <input type="checkbox"/>		Cell <input type="checkbox"/> House <input type="checkbox"/> Work	
Race: (Check all that apply)		Employment or Income Status		Do you provide financial support to the family?	
<input type="checkbox"/> American or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Multi Racial/Biracial <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other: _____		<input type="checkbox"/> Full time <input type="checkbox"/> Part time (less than 30 hrs per week) <input type="checkbox"/> I have more than 1 job or Self-employment <input type="checkbox"/> Unemployed (looking for a job) <input type="checkbox"/> Training or School <input type="checkbox"/> Child Support <input type="checkbox"/> Retired or disabled. <input type="checkbox"/> SSI(Alimony)		<input type="checkbox"/> No <input type="checkbox"/> Yes (Explain): _____	
School Level: <input type="checkbox"/> High school graduate or less <input type="checkbox"/> High School graduate/GED <input type="checkbox"/> associate degree, vocational school, or some college <input type="checkbox"/> Advanced degree or baccalaureate degree <input type="checkbox"/> Job training or currently studying (ESL, GED) Other: _____					
Parent/Guardian Employment #1 Information:					NO Applies
Employer's Name _____ Address _____					
City _____ Zip Code _____ Employment Telephone _____					
Where do you work? _____ Position or Title: _____ Your Current Job Yes or No					
Parent/Guardian Employment#2 Information:					NO Applies
Employer's Name _____ Address _____					
City _____ Zip Code _____ Employment Telephone _____					
Where do you work? _____ Position or Title: _____ Your Current Job Yes or No					

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Summit County Head Start Program 0-5

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Adult Information #2					
Name	Initial	Last Name	Date of Birth	Sex	Language:
				M F	Primary:
					Secondary:
Do you reside with the applicant child?	<input type="checkbox"/> Yes <input type="checkbox"/> No (Please share your address if you are not living with the child) Zip code: _____				English Skills: <input type="checkbox"/> Nothing <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient
Relationship with the Child:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent/Guardian Relative <input type="checkbox"/> Other: _____			Phone Number: _____	
Email:			How do you prefer to be contacted? <input type="checkbox"/> Call <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/>		<input type="checkbox"/> Cell <input type="checkbox"/> House <input type="checkbox"/> Work
Race: (Check all that apply)		Employment or Income Status			Do you provide financial support to the family?
<input type="checkbox"/> American or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Multi Racial/Biracial <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other: _____ Hispanic/Latino: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Full time <input type="checkbox"/> Part time (less than 30 hrs per week) <input type="checkbox"/> I have more than 1 job or Self-employed <input type="checkbox"/> Unemployed (looking for a job) <input type="checkbox"/> Training or School <input type="checkbox"/> Child Support <input type="checkbox"/> Retired or disabled. <input type="checkbox"/> SSI(Alimony)			<input type="checkbox"/> No <input type="checkbox"/> Yes (Explain): _____
School Level: <input type="checkbox"/> High school graduate or less <input type="checkbox"/> High School graduate/GED <input type="checkbox"/> associate degree, vocational school, or some college <input type="checkbox"/> Advanced degree or baccalaureate degree <input type="checkbox"/> Job training or currently studying (ESL, GED) Other: _____					
Parent/Guardian Employment Information:				NO Applies	
Employer Name#1 _____ Address _____ City _____ Zip Code _____ Employment Telephone _____ Where do you work? _____ Position or Title: _____ Your Current Job Yes or No					
Parent/Guardian Employment Information:				NO Applies	
Employer Name#1 _____ Address _____ City _____ Zip Code _____ Employment Telephone _____ Where do you work? _____ Position or Title: _____ Your Current Job Yes or No					

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Family Information

**Please list all the people living in your household.
DO NOT INCLUDE ANYONE FROM THE TWO ADULT
PAGES ABOVE**

Name	Last Name	DOB	Sex	Race	Language	Relationship with the Applicant
			M F			
			M F			
			M F			
			M F			
			M F			
Total number of family members supported by Primary and Secondary Adults:						

Additional Family Information: (please answer each question)

Other Additional Information:	Military or Tribal Family <input type="checkbox"/> Yes <input type="checkbox"/> No The family is in a US Asylum or Refugee process <input type="checkbox"/> Yes <input type="checkbox"/> No	Sibling in Early/Head Start Referred by social agency <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> HS-Policy Council Participant. <input type="checkbox"/> Participation in HS engagement educational events.	Public Assistance Housing <input type="checkbox"/> Yes <input type="checkbox"/> No Parent Has a Disability <input type="checkbox"/> Yes <input type="checkbox"/> No Teen Parent <input type="checkbox"/> Yes <input type="checkbox"/> No	Domestic Violence Services (past or present) <input type="checkbox"/> Yes <input type="checkbox"/> No Substance or Alcohol Abuse (past or present) <input type="checkbox"/> Yes <input type="checkbox"/> No

How did you hear about the Summit Head Start Program programs? Family or Friend Flyer Previously Enrolled Child Website Other: _____

Would you be interested in receiving information about other provider options or home care support grants (Licensed Home Providers)? Yes No.

Parent/Guardian, please read each statement and initial.

_____ Summit County Head Start Program **will not provide services to those families who do not live or work within the Summit County City limits.** If you move during the school year, you must contact us.

_____ Summit County Head Start does **not provide transportation.**

_____ I certify that all information provided above on this application is true and accurate to the best of my knowledge. I am aware that failure to answer all questions truthfully may negatively impact acceptance into the program.

Completing an application does not guarantee program enrollment.

Parent or Guardian Signature _____ Date _____

Signature of the Personal _____ Date _____

Office Use Only: Application entered by: _____ Date: _____

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The Summit Head Start Program does not discriminate based on race, color, national origin, sex, religion, age, or disability in the provision of services.