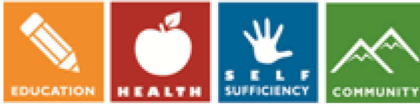


Summit Head Start 0-5
PO Box 3355/330 Fiedler Ave. Suite 208
Dillon, CO 80435
Fax 970.468.7923

Application

Thank you for your interest in Early Head Start and/or Head Start 0-5.
Summit Head Start 0-5 is able to serve 35 children ages 3-5 and 24 children ages 6 weeks to 3 years old and one pregnant woman. Head Start is an income-qualifying program. Families with children with special needs are encouraged to apply. 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

The Head Start 0-5 program is a partnership between Summit County Government, Summit School District, Early Childhood Options, Summit County Preschool, Lake Dillon Preschool, Clayton Early Learning and Carriage House Early Learning Center.

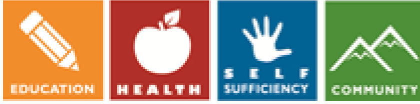
As part of the process of recruiting eligible children and their families, the following information is required. Please complete and return the following to us:

______Completed Application
______Signed Interagency Release
______Family Income Verification for the last 12 months (e.g., W-2, paystubs, employer letter verifying income) OR _______ Residency Verification
______Copy of Child's Birth Certificate
______ASQ3 & ASQSE 2 Parent Questionnaires

Families applying for full year, full day childcare/preschool will be asked to also apply for the Colorado Child Care Assistance Program (CCCAP) when available.

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

Family Engagement Specialists (English/Spanish)
Damarys Peralta 970.406.3070 *bilingual
Jordan Rugama 970.406.3063 *bilingual



Summit Head Start 0-5
Eligibility Application 2021-2022

Please fill out application completely. All the information will be kept confidential and only shared to determine appropriate placement.

Child's Name: ____
First Name Middle Name Last Name

Date of Birth: ____________________ **Sex:** ☐ Masculine ☐ Feminine

Has your child previously been enrolled in Head Start or Early Head Start? ☐ Yes ☐ No

If yes, please write the name of the program: ____________________

How did you hear about Head Start? ______________________________

Race: ☐ White ☐ Native American/ Alaskan Native ☐ Asian
☐ Black/Afro-American ☐ Hawaiian or Pacific Islander ☐ Multi-Racial

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Child's primary language: ______________________________

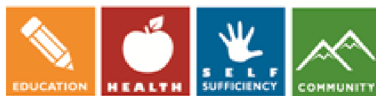
Family Type:
☐ Two parent household
☐ Single parent household
☐ Parent lives with a partner
☐ Parents are divorced/separated
☐ Blended family
☐ Foster family
☐ Lives with grandparent or guardian

Parent/Guardian #1

Name: ______________________________ **Date of Birth** :______________
Phone Number: ______________ **Lives with child?** ☐ Yes ☐ No
Relationship to child: ____________________**Provides Financial Support?** ☐ Yes ☐ No
Place of Employment: ______________________ **E-mail:** ______________________
Employment Status
☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Disabled ☐ Home ☐ Seasonal
☐ Full-time student ☐ Part-time student
Highest Grade Completed
☐ 9º or less ☐ Some High School ☐ High School Diploma/GED ☐ Some College
☐ Associates ☐ Bachelors ☐ Masters ☐ Doctorate
Language: ____________________ **English Proficiency** ☐ None ☐ Little ☐ Moderate ☐ Proficient
Are you pregnant? ☐ Yes ☐ No ☐ Doesn't Apply Due Date? ________________

Parent/Guardian #2 (even if 2nd parent/guardian/caregiver is not in the same household as child)

Name: ______________________________ **Date of Birth** :______________
Phone Number: ______________ **Lives with child?** ☐ Yes ☐ No
Relationship to child: ____________________**Provides Financial Support?** ☐ Yes ☐ No
Place of Employment: ______________________ **E-mail:** ______________________
Employment Status
☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Disabled ☐ Home ☐ Seasonal
☐ Full-time student ☐ Part-time student
Highest Grade Completed
☐ 9º or less ☐ Some High School ☐ High School Diploma/GED ☐ Some College
☐ Associates ☐ Bachelors ☐ Masters ☐ Doctorate
Language: ____________________ **English Proficiency** ☐ None ☐ Little ☐ Moderate ☐ Proficient
Are you pregnant? ☐ Yes ☐ No ☐ Doesn't Apply Due Date? ________________



Summit Head Start 0-5
General Information

Mailing Address: ____
City State Zip Code

Physical Address: ____
(If different) City State Zip Code

Alternate contact person: ______________________ **Phone number:** ______________

Service preference (if you're applying for Early Head Start, ages 0-3)
☐ Childcare for EHS (0-3 year olds) ☐ Prenatal

School of preference (if you're applying for Head Start, ages 3-5)
☐ Dillon Valley Elementary ☐ Silverthorne Elementary ☐ Summit County Preschool
☐ Upper Blue Elementary ☐ Lake Dillon Preschool ☐ Carriage House Early Learning Center

Number of bedrooms:_______________

How many people live with the child (including family members and roommates): _______________
Name ______________________ Gender ____ DOB ___________ Relationship _______________
Name ______________________ Gender ____ DOB ___________ Relationship _______________
Name ______________________ Gender ____ DOB ___________ Relationship _______________
Name ______________________ Gender ____ DOB ___________ Relationship _______________
Name ______________________ Gender ____ DOB ___________ Relationship _______________

Type of services family is currently receiving (mark all that apply): ☐ N/A
☐ TOB Tuition Assistance
☐ TANF -Public assistance/welfare
☐ Unemployment benefits
☐ LEAP - Energy program assistance
☐ FU/FIRC -Families United home visitation
☐ Medicaid/Medicare
☐ CHP+
☐ Public housing
☐ Child support/alimony
☐ Foster care/adoption subsidy
☐ NFP -Nurse Family Partnership
☐ Food Stamps (SNAP)
☐ SSI-Supplemental Security Income
☐ WIC- Women, Infant, Children
☐ Kinship assistance
☐ CCCAP- Child Care Assistance Program
☐ SFOP- Strengthening Families
☐ Advocates for Victims of Assault
☐ Other (please list):

Family circumstances within the immediate household (mark all that apply): ☐ N/A
☐ Substance abuse/treatment
☐ Domestic violence
☐ Loss of family member through separation/divorce
☐ Loss of family member through death
☐ Incarcerated family member (in the last 12 months)
☐ Family member other than child with medical issue, disability/special need
☐ Family member or child with or receiving mental health support
☐ Parent deported
☐ Abuse/neglect of child

Was the family impacted by pandemic: ☐ Yes ☐ No
The family experienced one or more of the following: Loss of housing, loss of employment, had food security concerns, family was worried about providing meals, affording food costs, consistently accessing food banks a/o COVID specific food programs, someone in the immediate household had a positive COVID-19 test result, or COVID-19 related death in the household.

Was the applicant child premature? _______
If yes, how many weeks? _______

Was the oldest child born when parent was under 18 years of age & unmarried ☐ Father ☐ Mother ☐ N/A
At least one parent/Guardian is a member of the Unites Stated Military ☐ Yes ☐ No
Do you have internet access at home? ☐ Yes ☐ No
Do you have stable housing? ☐ Yes ☐ No
Is at least one parent/guardian's names listed on the lease? ☐ Yes ☐ No
In the last 12 months, did you live in a car, shelter, campground, park, or rely on friends or relatives for housing?
☐ No ☐ Yes (Please circle which one)
How many times has the family moved in the last 12 months? 0 1 2 3 4

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

Parent/guardian signature: ______________________________ **Date:** _______________

Health Home

1. Does applicant have a Medical Home and/or access to continuous Health Care? ☐ Yes ☐ No

Special Needs Concerns

1. Do you have any concerns about your child? ☐ Yes ☐ No
2. Does your child have any allergies? ☐ Yes ☐ No

If yes, please explain: ______________________________

____

____

____

____

____

Has this been diagnosed by a professional? ☐ Yes ☐ No

2. Has your child ever received special education services or early intervention? ☐ Yes ☐ No
3. Is your child on an Individualized Education Plan (IEP)? ☐ Yes ☐ No

If yes, please write where child was attending: ______________________________

4. Is your child on an Individualized Family Service Plan (IFSP)? ☐ Yes ☐ No

If yes, please write where child was attending: ______________________________

5. Do you have any special education documentation? ☐ Yes ☐ No ☐ Not applicable

*If you marked yes to any of these questions, please fill out a Release of Information form.

List any additional information you would like us to be aware of: ______________________________

____

Name of specialist/ clinic/ school district that works with your child (name of doctor, clinic, etc.):______________________________

Phone number ________________________

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

Parent/guardian signature: ______________________________ **Date:** ______________

Consent for the Release of Confidential Information
Summit Head Start 0-5

Child's Name: ______________________________ Date of Birth: ________________

I ____________________ (printed name of parent/guardian) authorize the Summit Head Start (HS0-5) Program to 1) include the information I provide on enrollment and assessment paperwork in confidential, secure databases*, 2) share my child's name and DOB with Summit School District in order to track long-term outcomes for HS0-5 participants, and 3) disclose and exchange information about my case with relevant partner staff and the following organizations/programs:

HS0-5 Partners—HS0-5 partners with several agencies to deliver program services. It will be necessary for us to share child information to determine enrollment and maintain enrollment with the following:

Early Childhood Options (ECO)
Family & Intercultural Resource Center (FIRC)
Summit School District (SSD)
Summit County Preschool
Lake Dillon Preschool
Clayton Early Learning
Results Matter (state ECE initiative)
Carriage House
-Building Hope
-Breckenridge Childcare Tuition Assistance

Summit County Government
-Early Intervention Colorado (EI)
-Public Health Nurses
-Women Infants & Children Program (WIC)
-CCCAP (Colorado Child Care Assistance Program)
-Human Services
-Summit County Right Start Project (county ECE initiative)
-Mili Sarmiento Shoemaker, LPC, RPT-S
- Advocates for Victims of assault
- Smart Bellies

____**Please initial**

Health Tracking—If enrolled, HS0-5 is required to track health information. Please provide names of any additional health providers you work with so we may contact them to share medical information. I authorize the following providers to exchange my medical and dental health information with Summit County Head Start 0-5:

Centura/High Country Healthcare (HCHC)
Summit County Public Health
Dr. Ebert Santos
Summit Community Care Clinic
Pediatric Dental Group
All Kids Dental P.C.

Health Care Providers: ______________________________

Dental Care Providers: ______________________________

Other: ______________________________

Please inform HS0-5 staff if you change primary health providers.

________**Please initial**

Additional Support—To support you and your family, we work with many other community partners. Please initial the additional organizations you allow us to share information with.

_____ **Advocates for Victims of Assault**
_____ **Colorado Mountain College (ESL & Family Literacy)**
_____ **Colorado Workforce Center**
_____ **Summit County Child Care Centers/Licensed Child Care Providers**
_____ **Holiday Donation Agencies**
_____ **Nurse Family Partnership**
_____ **Strengthening Families (Y&F)**
_____ **NW Colorado Center for Independence**

*Names of databases given upon request.

I consent and understand that I can revoke my permission to release confidential information at any time. I understand that use of child data may be used for long term studies unless I sign for revocation of consent. I understand that some or all of the above listed agency personnel are required by law to report any suspected abuse and/or neglect.

______________________________ ________________
Parent/Guardian Signature Date

______________________________ ________________
EHS/HS Staff Signature Date

For Revocation of Consent Only

Date: ______________________________

Parent/Guardian Signature: ______________________________

Staff Signature: ______________________________