Red Cliff Early Childhood Center
CHILD APPLICATION

Head Start/Early Head Start is required to use the Department of Health and Human Services HHS Poverty Guidelines to determine income eligibility.

HOW DO I APPLY?

- ✓ **Complete an application along with copies of Parent(s)/Guardian(s) Income.**
- ✓ **After application is received, an application interview will be scheduled and application will be reviewed and an ASQ-3, ASQ-SE2 and other screens will be completed.**
- ✓ **Completing the application process does not guarantee enrollment**
- ✓ **Applicants are accepted based upon income (Federal Poverty Level) and prioritized using approved selection criteria**
- ✓ **Upon enrollment to the program, applicants will receive an "Acceptance" letter and important information about scheduling an enrollment appointment for your child.**

Please Note:

1. **Enrollment is limited, so please complete your application & enrollment appointment immediately for early consideration.**
2. **An incomplete application, including no documentation, will delay the enrollment process. Selection for fall enrollment openings will be released July 15th of each year.**

Policy Council approved 7/18/17 JD
Tribal Council approved 10/2/17 JD

Red Cliff Early Childhood Center
88455 Pike Rd (mail)
89830 Tiny Tot Drive (physical)
Bayfield, WI 54814
(715) 779-5030
(715) 779-5046 fax
www.redcliffecc.org

Head Start/Early Head Start Child Application

Application for: **Head Start** ☐ **Early Head Start** ☐ **Child Care** ☐

APPLICANT (CHILD) INFORMATION

Child First Name (Please Print)	**Middle Initial**	**Last Name** (Please Print)

Actual Due Date:_____
Premature Birth? ☐ Yes ☐ No
# of weeks premature_____

Date of Birth
_____/_____/_____
Mo *Day* *Year*

Gender
☐ Male ☐ Female

Hispanic? ☐ Yes ☐ No **Race:** ☐ Asian ☐ White ☐ Native American/Alaskan Native ☐ Other
☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Multi Racial/Biracial

Is the child enrolled in a federally recognized tribe? ☐ Yes ☐ No
If yes, **Tribal Affiliation** _____
Is the child a tribal descendent OR eligible for enrollment? ☐ Yes Tribe:_____

Child Primary Health Coverage/Insurance: ☐ Badgercare/Medicaid ☐ Private Health Insurance ☐ IHS
Child Doctor/Medical Home: _____ **Child Dentist/Dental Home:** _____

PRIMARY ADULT (Parent/Legal Guardian) INFORMATION

First Name	*Middle*	*Last Name*	Gender	Date of Birth
			☐ Male ☐ Female	_____/_____/_____ Mo Day Year

Relationship to Child: ☐ Parent ☐ Step-Parent ☐ Guardian ☐ Grand Parent ☐ Foster Parent Other: _____

Lives with Family ☐ **Provides Financial Support** ☐ **Custody** ☐

Hispanic: Yes ☐ No ☐

Race (check all that apply):
☐ Native American/Alaskan Native
☐ White
☐ Asian
☐ Multi-Racial/Biracial
☐ Black/African American
☐ Other:_____

Language Spoken: English ☐
Spanish ☐ Other:_____

Highest Grade/Education Completed:
☐ GED/HSED
☐ HS Graduate
☐ < Grade 9
☐ Grade 10
☐ Grade 11
☐ Associate's Degree
☐ Bachelor's Degree
☐ Master's Degree

Are you enrolled in: Job Training ☐ or School ☐
Do you anticipate completing your education and/or job training program during the school year? Yes ☐ No ☐

Member of U.S. Military **Active Duty**? Yes ☐ No ☐
Veteran of the U.S. Military? Yes ☐ No ☐

Employment Status:
☐ Full Time
☐ Part Time
☐ Full Time & Trng.
☐ Part Time & Trng.
☐ Seasonally Employed
☐ Unemployed
☐ Retired or Disabled

Living Address:_____ City:_____State:_____Zip:_____
(Please Print Clearly)

Mailing Address: _____City:_____State:_____ Zip:_____
(if different) (*Please Print Clearly*)

Email Address:	Cell	Home	Work
Primary Adult Phone Number:*(please print clearly)*	☐ Opt for text msg / /	/ /	/ /

SECONDARY ADULT (Parent/Legal Guardian) INFORMATION

First Name	*Middle*	*Last Name*	*Date of Birth* _____/_____/_____ *Mo Day Year*	*Gender* ☐ Male ☐ Female

Relationship to Child: ☐ Parent ☐ Step-Parent ☐ Guardian ☐ Grand Parent ☐ Foster Parent Other: _____

Lives with Family ☐ **Provides Financial Support** ☐ **Custody** ☐

Living Address: _____City:_____State:_____Zip:_____
Secondary Adult Phone: (*Please Print Clearly*) Cell: _____/_____/_____ Home: ____/_____/_____

Hispanic? ☐ Yes ☐ No

Race (check all that apply):
- ☐ NativeAmerican/Alaskan Native
- ☐ White
- ☐ Asian
- ☐ Multi-Racial/Biracial
- ☐ Black/African American
- ☐ Other _____

Primary Language: ☐ English ☐ Spanish Other _____

Highest Grade/Education Completed:
- ☐ GED/HSED
- ☐ High School Graduate
- ☐ < Grade 9
- ☐ Grade 10
- ☐ Grade 11
- ☐ Associate's Degree
- ☐ Bachelor's Degree
- ☐ Master's Degree

Are you enrolled in: ☐ Job Training or ☐ School
Do you anticipate completing your education and/or job training program during the HS program year? ☐ Yes ☐ No

Member of U.S. Military **Active Duty**? ☐ Yes ☐ No
Veteran of the U.S. Military? ☐ Yes ☐ No

Employment Status:
- ☐ Full Time
- ☐ Part Time
- ☐ Part Time & Trng.
- ☐ Full-Time & Trng.
- ☐ Seasonally Employed
- ☐ Unemployed
- ☐ Retired or Disabled

OTHER FAMILY MEMBERS SUPPORTED BY PRIMARY/SECONDARY ADULT (LIVING IN THE HOME)

Last	First	D.O.B.	Relationship to Child

Total # of Children:_____ Total # Adults: _____ Total # of Family Members:

CHILD EMERGENCY CONTACTS: (3 contacts required)

Name: _____Relationship to child:_____Phone:_____ ☐ Contact ☐ Release to

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Name: _____Relationship to child:_____Phone:_____ ☐ Contact ☐ Release to

If enrolled in center-based program, would you like to be contacted about child care services?
Yes ☐ **No** ☐

Do you authorize your Head Start child to be transported by ECC school bus?
Yes ☐ **No** ☐

Do you authorize ECC to share your name and contact number with Zaagichigaazowin Home Visiting Program?
Yes ☐ **No** ☐

	Yes	No		Yes	No
Child history of neglect/abuse			HS/EHS child is a Foster Child		
Death of child's parent/sibling			Supplemental Security Income (SSI)		
Parent in prison/incarceration			TANF/W-2		
Substance Abuse in child's primary home			Is your family Homeless? *(Definition: Lack of a fixed, regular, and adequate nighttime residence; <u>includes living with family or friends</u>)*		
Parent does not have HSED/GED					
Domestic Violence in child's primary home					
Premature birth (before 35 weeks)					
Prenatal Substance Use with this child: ☐ Drugs OR Alcohol ☐ Tobacco					
Diagnosed Mental Illness (Primary/Secondary Caretaker) ☐ Anxiety ☐ Bi-polar ☐ ADHD ☐ PTSD ☐ Depression ☐ Other:			DISABILITY STATUS (Child)	Yes	No
Child Behavior/Management Concerns			Certified I.E.P. (Individualized Education Plan)		
First Time Parent (Both)			Certified I.F.S.P. (Individualized Family Service Plan)		
Any Other Special Family Need/Circumstance you would like us to consider? (please describe):			Suspected Disability or Delay: Please explain:		
			Serious Health issues: Please explain:		

Parental Status: (Check all that apply) ☐ One Parent in the home ☐ Both Parents in the home
☐ Foster Parent (to this child) ☐ Kinship Care Provider (to this child) ☐ Teen Parent ☐ Grandparent ☐ Disabled Parent ☐ Dual Custody

Family Receives: ☐ Food Share/SNAP/Food Stamps ☐ WIC ☐ Wisconsin Shares (Child Care)

PARENT/GUARDIAN INCOME STATUS (Before Taxes)

The following information is required to process your child's application:

Income Tax Form; W-2's; Pay Stubs; Public Assistance: TANF-W-2; and SSI-Disability Payment Verifications. Income to be submitted & verified must include the last 12 months of the preceding calendar year

The following is requested: most current Physical and Dental Exam and Immunization Record

Mother/Legal Guardian/Relative Caregiver	Father/Legal Guardian/Relative Caregiver
Employer _____Employed Since_____	Employer _____Employed Since_____
Full Time ☐ Part-Time ☐ Seasonal ☐	Full Time ☐ Part-Time ☐ Seasonal ☐
Gross Income $_____	**Gross** Income $_____
Weekly ☐ Bi-Wkly ☐ Monthly ☐ Yrly. ☐	Weekly ☐ Bi-Wkly ☐ Monthly ☐ Yrly. ☐
W-2 or Tax Return $ _____ Total: _____	W-2 or Tax Return $ _____ Total: _____

OTHER INCOME & CASH ASSISTANCE
(Documents & Verification Required) (Including Child's Income)

Social Security Benefits (monthly)	SSI (monthly)	TANF/W-2 (monthly)	Child Support (monthly)	Foster/Kinship Care (monthly)	Unemployment (weekly)	Other Income (List)
$	$	$	$	$	$	$

I certify that my family's assets are less than $100,000. ☐ **Yes** ☐ **No**

Please Read Before Signing

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT ALL INCOME IS REPORTED. I UNDERSTAND THAT THE INFORMATION IN THIS APPLICATION WILL BE HELD IN STRICT CONFIDENCE WITHIN THE PROGRAM. I ALSO UNDERSTAND THAT THIS INFORMATION IS BEING GIVEN TO DETERMINE ELIGIBILITY FOR A FEDERAL PROGRAM AND WILL BE VERIFIED FOR ACCURACY. PROVIDING FALSE INFORMATION FOR ELIGIBILITY PURPOSES MAY RESULT IN NON-ACCEPTANCE.

Parent Signature: _____ **Date:** _____

---***This Section for Program Use Only***---

Type of Eligibility: ☐ *Income below 100% Poverty Line* ☐*100-130% Above Poverty Line*
☐*Public Assistance* ☐*Homeless* ☐ *Status as a Foster Child* ☐ *Disability*
Wait list Date: _____ *Wait list Classroom/s:* _____
☐ *Entered on ChildPlus* *Total Eligibility Income:* _____ *Family of:* _____