Red Cliff Early Childhood Center
PRENATAL 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 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

**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.
Early Head Start
Pregnant Women/Expectant Families
Application-Intake

Date of Application-Intake: ______________________

Pregnant Woman Name: ____________________________ Date of Birth: ____/____/_____

Address: __________________________________________

Street: ___________________________ City: ___________________________ Zip Code: __________

County: ___________________________

Phone: (_____) _______ - _______ Message Phone: (_____) _______ - _______ Tribal Affiliation: ___________________________

Hispanic: Yes ☐ No ☐

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

Family Receives:
☐ Food Share/SNAP ☐ WIC
☐ Wisconsin Shares (child care)
☐ TANF ☐ General Assistance

Highest Grade/Education Completed:
☐ GED/HSED
☐ HS Graduate
☐ < Grade 9
☐ Grade 10
☐ Grade 11

Associate’s Degree
☐ Bachelor’s Degree
☐ Master’s Degree
☐ Other

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

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

Veteran of the U.S. Military?
Yes ☐ No ☐

Spouse or Partner Name: ____________________________ Date of Birth: ____/____/_____ Phone: (_____) _______ - _______ Tribal Affiliation: ___________________________

Lives with Applicant ☐ Provides Financial Support ☐

Hispanic: Yes ☐ No ☐

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

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Associate’s Degree
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☐ Other

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

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

Veteran of the U.S. Military?
Yes ☐ No ☐

Other Family Members Financially Supported by Primary/Secondary Adult (Living in the Home)

<table>
<thead>
<tr>
<th>First &amp; Last Name</th>
<th>D.O.B.</th>
<th>Relationship to Applicant</th>
</tr>
</thead>
</table>

Total # of Children: ____
Total # Adults: ____
Total # in household: ____
**PARENT(S)/GUARDIAN(S) INCOME STATUS (Before Taxes)**

**The following information is required to process this application:**

- **Income Verification:** Tax Form or W-2’s; Pay Stubs;
- **Public Assistance:** TANF-W-2; and/or SSI-Disability Payments
- **Other:** child support payments, etc.

<table>
<thead>
<tr>
<th></th>
<th>Applicant</th>
<th>Spouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer</td>
<td>_____________________________________________</td>
<td>___________________________________________</td>
</tr>
<tr>
<td></td>
<td>□ Full Time</td>
<td>□ Full Time</td>
</tr>
<tr>
<td></td>
<td>□ Part-Time (less than 30 hrs. /week)</td>
<td>□ Part-Time (less than 30 hrs. /week)</td>
</tr>
<tr>
<td><strong>Gross Income</strong></td>
<td>___________</td>
<td>___________</td>
</tr>
<tr>
<td></td>
<td>W-2 or Tax Return $ ___________</td>
<td>W-2 or Tax Return $ ___________</td>
</tr>
</tbody>
</table>

**OTHER INCOME & CASH ASSISTANCE**

*(Documents & Verification Required)*

<table>
<thead>
<tr>
<th>Social Security Benefits (monthly)</th>
<th>SSI (monthly)</th>
<th>TANF/W-2 (monthly)</th>
<th>Child Support (monthly)</th>
<th>Foster/Kinship Care (monthly)</th>
<th>Unemployment (weekly)</th>
<th>Other Income (List)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
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</table>

**Family of:** ___________

**Total Income:** ____________

**Family Circumstances** *(Please check all that apply to you or your immediate family)*

- □ Child Protection Services
- □ Foster Care/Kinship Care
- □ Death of immediate family member
- □ Incarcerated Parent
- □ Lack of Prenatal Care
- □ High Risk Pregnancy
- □ Teen Parent
- □ Prenatal Substance Use with current pregnancy
  - □ Drugs □ Alcohol □ Tobacco
- □ Disabled Parent
- □ Multiple Births (twins, triplets, etc.)
- □ Domestic Violence
- □ Single Parent
- □ Lack of stable Housing or Homelessness
- □ First Time Parent
- □ Mental Health Concerns (Depression, Anxiety, etc.)
  - □ Concern □ Diagnosed (Please explain)

Any other concerns you would like us to know about:

________________________________________________________________________

**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.

**Signature:** _____________________________________________  **Date:** __________________________

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**This Section for Agency Use Only**

<table>
<thead>
<tr>
<th>Type of Eligibility:</th>
<th>□ Income below 100% Poverty Line</th>
<th>□ 100-130% Above Poverty Line</th>
<th>□ Public Assistance</th>
<th>□ Homeless</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Foster Care (applicant)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accepted Date:</td>
<td>_______________________________</td>
<td>Wait list Date: __________</td>
<td>Wait list Home Visitor: _______________</td>
<td></td>
</tr>
</tbody>
</table>
**Pregnancy/Health Information**

Do you have regular Prenatal Health Care: □ No  □ Yes

Primary Health Coverage/Insurance: □ Badgercare/Medicaid □ Private Health Insurance □ IHS □ None

Last DENTAL exam: ____________________________ Clinic/Provider: ____________________________

Prenatal Care Physician (OB-GYN): ____________________________

Date of first Prenatal Care Visit: ____________________________

When did you begin receiving prenatal care: □ 1st Trimester  □ 2nd Trimester  □ 3rd Trimester

Due Date: ____________________________ (Pregnancy Verification Required)

Is this a high-risk pregnancy: □ Yes □ No  □ Yes □ No

Is this your first pregnancy? □ Yes □ No

Complications

<table>
<thead>
<tr>
<th>Current</th>
<th>Past</th>
</tr>
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<tbody>
<tr>
<td>Anemia</td>
<td>□</td>
</tr>
<tr>
<td>Bleeding</td>
<td>□</td>
</tr>
<tr>
<td>C-Section</td>
<td>□</td>
</tr>
<tr>
<td>Diabetes</td>
<td>□</td>
</tr>
<tr>
<td>Fatigue</td>
<td>□</td>
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<tr>
<td>Headache</td>
<td>□</td>
</tr>
<tr>
<td>Hypertension</td>
<td>□</td>
</tr>
<tr>
<td>Miscarriage</td>
<td>□</td>
</tr>
<tr>
<td>Neonatal Death</td>
<td>□</td>
</tr>
<tr>
<td>Pain</td>
<td>□</td>
</tr>
<tr>
<td>Pre-Term Labor</td>
<td>□</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>□</td>
</tr>
<tr>
<td>Induced hypertension</td>
<td>□</td>
</tr>
<tr>
<td>Sickle Cell</td>
<td>□</td>
</tr>
<tr>
<td>Swelling</td>
<td>□</td>
</tr>
</tbody>
</table>

Current bed rest or Hospitalization due to ___________ How long ___________

Previous bed rest or Hospitalization due to ___________ How long ___________

Do you have any other current health problems or concerns? □ No  □ Yes ____________________________

Are you currently enrolled in Zaagichigaazowin Home Visiting Program?  □ Yes  □ No

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