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?

✓ Please call (715) 779-5030 ext 0 to schedule an enrollment appointment
✓ At the time of your appointment, you are required to bring:
  Parent(s)/Guardian(s) Income along with the completed application
✓ Completing the application process does not guarantee enrollment
✓ Applicants are accepted based upon income (Federal Poverty Level) and prioritized using approved selection criteria
✓ Upon acceptance to the program, applicants will receive an “Acceptance” letter

Please Note:

1. Space is limited, so please complete your application & enrollment appointment immediately for early consideration.
2. An incomplete application (no documentation) will not be accepted & will delay the enrollment process.
3. 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: ________________

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

Hispanic: Yes ☐ No ☐

Family Receives: ☐ Food Share/SNAP ☐ WIC
☐ Homeless

Highest Grade/Education Completed:
☐ GED/HSED ☐ HS Graduate ☐ Associate’s Degree
☐ < Grade 9 ☐ Grade 10 ☐ Bachelor’s Degree
☐ Grade 11 ☐ Grade 12 ☐ Master’s Degree

Received:
☐ vocational/trade or ☐ business school trng.

Other Programs:
☐ TANF ☐ General Assistance

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

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

Member of U.S. Military?
Yes ☐ No ☐

Spouse or Partner Name: ____________________________ Date of Birth: ____/____/____

Phone: (____) _______ - _______ Tribal Affiliation: ________________

Lives with Applicant ☐ Provides Financial Support ☐

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

Hispanic: Yes ☐ No ☐

Highest Grade/Education Completed:
☐ GED/HSED ☐ HS Graduate ☐ Associate’s Degree
☐ < Grade 9 ☐ Grade 10 ☐ Bachelor’s Degree
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☐ Skills Training Program

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

Member of 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>
<th>Total # of Children:</th>
<th>Total # Adults:</th>
<th>Total # in household:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
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.

PARENT(S)/GUARDIAN(S) INCOME STATUS (Before Taxes)

Type of Eligibility: □ Income below 100% Poverty Line   □ 100-130% Above Poverty Line
□ Public Assistance   □ Homeless   □ Foster Care (applicant)

Accepted/Enroll Date: _________   Wait list Date: _____   Home Visitor: __________________

Applicant

Employer ___________________   Employed Since: _________

Full Time   □ Part-Time (less than 30 hrs. /week

Gross Income $___________

Paid: □ Weekly   □ Bi-Wkly   □ Monthly

W-2 or Tax Return $ ________________

Spouse

Employer ___________________   Employed Since: _________

Full Time   □ Part-Time (less than 30 hrs. /week

Gross Income $___________

Paid: □ Weekly   □ Bi-Wkly   □ Monthly

W-2 or Tax Return $ ________________

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>
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</tr>
</tbody>
</table>

Family of: ________   Total Income: ____________

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

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

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: ____________________
Pregnancy/Health Information

Do you have regular Prenatal Health Care: □ No □ Yes  
First Received Prenatal Care: ________________________

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  
Is this your first pregnancy? □ Yes □ No

Complications

<table>
<thead>
<tr>
<th>Current</th>
<th>Past</th>
<th>Current bed rest or Hospitalization due to _________ How long ________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Bleeding</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>C-Section</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Diabetes</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Fatigue</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Headache</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Hypertension</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Miscarriage</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Neonatal Death</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Pain</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Pre-Term Labor</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Induced hypertension</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Sickle Cell</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Swelling</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Previous bed rest or Hospitalization due to _________ How long ________

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

Do you authorize ECC to share your name with Zaagichigaazowin Home Visiting Program?

Yes □ No □

Are you currently enrolled in Zaagichigaazowin Home Visiting Program?

Yes □ No □

*Application updated 2-11-16 NB