



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.

Red Cliff Early Childhood Center
 88385 Pike Rd (mail)
 89830 Tiny Tot Drive (physical)
 Bayfield, WI 54814
 (715) 779-5030
 (715) 779-5046 fax
 www.redcliffecc.org

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: _____

<p>Race (check all that apply):</p> <p><input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Black/African American</p> <p>Hispanic: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Family Receives:</p> <p><input type="checkbox"/> Food Share/SNAP <input type="checkbox"/> WIC</p> <p><input type="checkbox"/> Homeless</p>	<p>Highest Grade/Education Completed:</p> <p><input type="checkbox"/> GED/HSED <input type="checkbox"/> Associate's Degree <input type="checkbox"/> HS Graduate <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> < Grade 9 <input type="checkbox"/> Master's Degree <input type="checkbox"/> Grade 10 <input type="checkbox"/> Grade 11 <input type="checkbox"/> Grade 12</p> <p>Received: <input type="checkbox"/> vocational/trade or <input type="checkbox"/> business school trng.</p> <p>Other Programs: <input type="checkbox"/> TANF <input type="checkbox"/> General Assistance</p>	<p>Employment & Training Status:</p> <p><input type="checkbox"/> Full Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonally Employed <input type="checkbox"/> Full Time & Trng. <input type="checkbox"/> Part Time & Trng. <input type="checkbox"/> Retired or Disabled <input type="checkbox"/> Training or School <input type="checkbox"/> Job Related Training Program <input type="checkbox"/> Skills Training Program</p> <p>Member of U.S. Military <u>Active Duty</u>? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Veteran of the U.S. Military? Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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Spouse or Partner Name: _____ Date of Birth: ____/____/____

Phone: (____) _____ - _____ Tribal Affiliation: _____

Lives with Applicant Provides Financial Support

<p>Race (check all that apply):</p> <p><input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Black/African American</p> <p>Hispanic: Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Highest Grade/Education Completed:</p> <p><input type="checkbox"/> GED/HSED <input type="checkbox"/> Associate's Degree <input type="checkbox"/> HS Graduate <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> < Grade 9 <input type="checkbox"/> Master's Degree <input type="checkbox"/> Grade 10 <input type="checkbox"/> Grade 11 <input type="checkbox"/> Grade 12</p> <p>Received: <input type="checkbox"/> vocational/trade or <input type="checkbox"/> business school trng.</p> <p>Other Programs: <input type="checkbox"/> TANF <input type="checkbox"/> General Assistance</p>	<p>Employment Status:</p> <p><input type="checkbox"/> Full Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonally Employed <input type="checkbox"/> Full Time & Trng. <input type="checkbox"/> Part Time & Trng. <input type="checkbox"/> Retired or Disabled <input type="checkbox"/> Training or School</p> <p>Member of U.S. Military <u>Active Duty</u>? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Veteran of the U.S. Military? Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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OTHER FAMILY MEMBERS FINANCIALLY SUPPORTED BY PRIMARY/SECONDARY ADULT (LIVING IN THE HOME)			
First & Last Name	D.O.B.	Relationship to applicant	
			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.

Applicant	Spouse
Employer _____ Employed Since _____	Employer _____ Employed Since _____
<input type="checkbox"/> Full Time <input type="checkbox"/> Part-Time (less than 30 hrs. /week)	<input type="checkbox"/> Full Time <input type="checkbox"/> Part-Time (less than 30 hrs. /week)
Gross Income \$ _____	Gross Income \$ _____
Paid: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Wkly <input type="checkbox"/> Monthly	Paid: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Wkly <input type="checkbox"/> Monthly
W-2 or Tax Return \$ _____	W-2 or Tax Return \$ _____

OTHER INCOME & CASH ASSISTANCE

(Documents & Verification Required)

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

Family of: _____ **Total Income:** _____

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

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

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:** _____

-----**This Section for Agency Use Only**-----

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: _____

Pregnancy/Health Information

Do you have **regular Prenatal Health Care**: No Yes **First Received Prenatal Care**: _____
(Date)

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

	<u>Current</u>	<u>Past</u>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
C-Section	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Miscarriage	<input type="checkbox"/>	<input type="checkbox"/>
Neonatal Death	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Pre-Term Labor	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Induced hypertension		
Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>
Swelling	<input type="checkbox"/>	<input type="checkbox"/>

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 _____

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