Eligibility Application Instructions

Thank you for your interest in Head Start! **Please read the following instructions thoroughly and complete the attached application.** Please bring the completed application with you to one of the application intake days.
Please fill out application with black/blue ink, no white out and no pencil.

Head Start is a comprehensive preschool program for income qualifying families and children with disabilities.

Eligibility Requirements for Head Start

- Child must be 3 or 4 years old by September 1st.
- Priority given to families whose income falls within the federal poverty guidelines or children with disabilities.
- The income requirements may be waived for:
  - Children with a diagnosed disability, we ask that you bring any records that you have relating to that disability (e.g. IEP).
  - Foster children
  - Children & families in high risk circumstances or families who meet the definition of 'homeless'.

The information you provide is voluntary and any information you provide will be kept confidential.

2016 Federal Poverty Guidelines	
# of people in family	Income Guidelines
1	11,880
2	16,020
3	20,160
4	24,300
5	28,440
6	32,580
7	36,730
8	40,890
9	45,050
10	49,210
11	53,370
12	57,530
For each additional person add $4,160	

To best serve you, all applicants are asked to come to one of the applications intake days so that a Head Start Staff member can meet with you and review your application.

For a schedule of application intake days, times and locations call the number listed below or look on our website.

If any of the items listed below are not provided with your application, the application will be considered incomplete and your child will not be considered for placement:

- ✓ **Child's birth documentation**
  - *Birth Certificate and/or Medicaid card (needs birthdate listed on card), baptism or blessing certificate, Foster Care placement letter, Hospital Certificate, I-94 or passport.*
- ✓ **Child's immunization record**
- ✓ **Proof of income for past 12 months: (bring all that apply)**
  - *1040 Tax Form - previous year (preferred)*
  - *W-2 Forms - previous year*
  - *Check Stub for past 12 months*
  - *Letter from Employer*
  - *TANF Letter*
  - *SSI/SSA/SSD Letter for previous year*
  - *Child Support*
  - *Unemployment*
  - *Foster Care Placement Letter*
  - *Grants/Scholarships/Fellowships/Assistantships*
- ✓ **Proof of Residence**
  - *Recent copy of utility bill, rental agreement or mortgage statement in parent's name that lists the address.*

Please also bring:

- ➢ *Copy of your child's most recent physical and dental exam. (completed in the last 12 months)*
- ➢ *Medicaid card, Medical and Dental Provider information.*

Head Start Program options include:

- Half-day (a.m. or p.m.) Monday-Thursday
- Full-day Monday-Thursday or Monday-Friday (families are not paying for the Head Start portion, which is 3 ½ hours, they are paying for the extended care, which is after the Head Start portion.)

For more information call 801-972-2337 email us at ERSEAteam@slcap.org or visit us on the web at www.saltlakeheadstart.org

Revised 03/16/2016

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Frequently Asked Questions

1. If I fill out an application, is my child guaranteed a spot?
Head Start/Early Head Start is not first-come first-served, but the sooner you turn in your application and complete documentation the better. Once your application is completed, it will then be processed and added to the pool. That means that all completed applications are considered every time a selection is made. Children are accepted into the Head Start program based on a prioritization process. Income eligible, Special Needs children and highest need will be considered for placement first.

2. When will I hear if my child is accepted in the program?
Applications will be processed as quickly as possible. If you turn in an application between March and August and your child is accepted, you will receive an email or an acceptance letter in the mail. The selection process will continue through the summer months until we have selected enough children to start the new program year. After school starts, we will then select children as vacancies open throughout the program.

3. When will I know what classroom my child will attend?
Once your child is accepted into our program their acceptance is final. In order to finalize your child's classroom placement, you will need to turn in your child's most recent (within last 12 months) physical and dental exam.

4. Why do you take applications when your classes are all full?
As children leave from the program, we use our selection process to select the child to fill the vacancy. Some children may not be selected at the beginning of the school year, but may be considered throughout the school year as vacancies occur.

5. What if I move after I submit my application?
If you move, change your phone number or your email address it is important that you notify us. This could affect your selection. We will need to communicate with you if your child is selected for enrollment. You can call the ERSEA Specialist Team at 801-743-6450 or email at ERSEATEAM@slcap.org to update your information.

6. What day will my child start school?
After receiving an acceptance notification, you will then receive a call to come to a meeting to finalize your classroom placement. You will be given an entry date at that time.

7. Does Head Start provide transportation?
We do not provide transportation for students; however, we provide information for resources available in the local community for transportation support. Please consider options such as your car, public transportation, friends, relatives, and childcare providers as possibilities.

8. May I call to check on my application?
You may contact us at anytime to request information about your application. If you want a response within 24 hours please email us at ERSEATEAM@slcap.org. Otherwise, call 801-743-6450 and we will return your call.

9. Where can I find more information about Salt Lake CAP Head Start?
www.saltlakeheadstart.org

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Eligibility Application

Please fill out application completely. All the information will be kept confidential.

Applicant & Family Member Information

Applicant (Child)

First	Middle Initial	Last	Suffix	Date of birth (mm/dd/yyyy)	Gender (M/F)	SSN # (last 4 digits)

Race (check only one)	Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial	☐ Yes ☐ No	☐ None ☐ Little ☐ Moderate ☐ Proficient	_____ ☐ **Not applicable**	☐ Poor ☐ Moderate ☐ Proficient ☐ **Not applicable**

How did you hear about Head Start?

☐ Family, friends, word of mouth
☐ Mail or flyer left at my home
☐ Poster or flyer (where?): _____
☐ Billboard
☐ Salt Lake CAP Head Start website
☐ Community agency (name): _____
☐ Fair or event (name/location): _____
☐ Facebook or other social media
☐ Electronic flyer (Peachjar)
☐ Other: _____

Primary Guardian

First	Middle Initial	Last	Suffix	Date of birth (mm/dd/yyyy)	Gender (M/F)	SSN # (last 4 digits)

English Proficiency	Other Language	Other Language Proficiency	Highest Grade Completed	
☐ None ☐ Little ☐ Moderate ☐ Proficient	_____ ☐ **Not applicable**	☐ Poor ☐ Moderate ☐ Proficient ☐ **Not applicable**	☐ Less than high school (0-8) ☐ Some high school (9-12) ☐ High school/GED ☐ Some college (no degree) ☐ Trade school/Certification	☐ Associates degree ☐ Bachelor's degree ☐ Master's degree ☐ Doctorate degree

Employment Status	Student Status	Do you receive?	Child's relationship	Custody	Check all that apply:
☐ Full time ☐ Part time ☐ Seasonal ☐ Homemaker ☐ Unemployed # of months_____ ☐ Retired or Disabled	☐ Full time ☐ Part time ☐ **Not applicable**	☐ Grants/Scholarships ☐ Fellowships ☐ Assistantships ☐ **Not applicable**	☐ Natural/Adopted/Step ☐ Grandchild ☐ Niece/Nephew ☐ Foster ☐ Other: _____	☐ Yes ☐ No	☐ Lives with applicant (child) ☐ Provides financial support ☐ Refugee ☐ Veteran ☐ Active duty (military) ☐ Deployed (military) ☐ Currently pregnant If so, due date: _____ ☐ **Not applicable**

Phone number	Type (check one)
	☐ Cell * ☐ Home ☐ Work ☐ Other
	☐ Cell * ☐ Home ☐ Work ☐ Other

***Head Start can text me information at the cell number(s) above.** ☐ Yes ☐ No ☐ **Not applicable**

Email:

Secondary or Other Guardian

First	Middle Initial	Last	Suffix	Date of birth (mm/dd/yyyy)	Gender (M/F)	SSN # (last 4 digits)

English Proficiency	Other Language	Other Language Proficiency	Highest Grade Completed	
☐ None ☐ Little ☐ Moderate ☐ Proficient	_____ ☐ **Not applicable**	☐ Poor ☐ Moderate ☐ Proficient ☐ **Not applicable**	☐ Less than high school (0-8) ☐ Some high school diploma (9-12) ☐ High school/GED ☐ Some college (no degree) ☐ Trade school/Certification	☐ Associates degree ☐ Bachelor's degree ☐ Master's degree ☐ Doctorate degree

Employment Status	Student Status	Do you receive?	Child's relationship	Custody	Check all that apply:
☐ Full time ☐ Part time ☐ Seasonal ☐ Homemaker ☐ Unemployed # of months_____ ☐ Retired or Disabled	☐ Full time ☐ Part time ☐ **Not applicable**	☐ Grants/Scholarships ☐ Fellowships ☐ Assistantships ☐ **Not applicable**	☐ Natural/Adopted/Step ☐ Grandchild ☐ Niece/Nephew ☐ Foster ☐ Other: _____	☐ Yes ☐ No	☐ Lives with applicant (child) ☐ Provides financial support ☐ Refugee ☐ Veteran ☐ Active duty (military) ☐ Deployed (military) ☐ Currently pregnant If so, due date: _____ ☐ **Not applicable**

Phone number	Type (check one)
	☐ Cell * ☐ Home ☐ Work ☐ Other
	☐ Cell * ☐ Home ☐ Work ☐ Other

***Head Start can text me information at the cell number(s) above.** ☐ Yes ☐ No ☐ **Not applicable**

Email:

Additional Child (Non-Applicant) **List children in household ages 0-3* ☐ *Not applicable*

First, middle initial, last name	Date of birth (mm/dd/yyyy)	Gender (M/F)

Alternate contact (Name of person(s) not living in the household)

(Child will not be released to person(s) below unless written on emergency card once the child is enrolled)

First, middle initial, last name	Phone number	Type (check one)
		☐ Cell ☐ Home ☐ Work ☐ Other
		☐ Cell ☐ Home ☐ Work ☐ Other
		☐ Cell ☐ Home ☐ Work ☐ Other

Family Information

Family Living Address

Living Address	City	State	Zip Code

Family Mailing Address

☐ Check box if same as living address

Mailing Address	City	State	Zip Code

Housing Situation

Type of Housing ☐ **Rent** ☐ **Own** ☐ **Not applicable (choose only one below)**

☐ House ☐ Apartment ☐ Mobile/Manufactured home ☐ Trailer ☐ Other: _____

1. Do you live in a combined household with other family members or individuals?
☐ Yes ☐ No

If yes, is this due to loss of housing or economic hardship?
☐ Yes ☐ No

2. How many times have you moved in the past 12 months? _____

3. Do you live in one of the following?
☐ Hotel/Motel room
☐ Community Shelter
☐ Domestic Violence Shelter
☐ Substance abuse treatment facility
☐ Car
☐ Public space (park/streets/abandoned building)
☐ **Not applicable (skip 3a. and 3b.)**

3a. Have you lived in one of the above for:
☐ Less than 12 months over the past 3 years **(skip 3b.)**
☐ 12 months or more over the past 3 years

3b. If 12 months or more over the last 3 years, has the head of household been diagnosed with any of the following?
☐ Substance use disorder
☐ Serious mental illness
☐ Developmental disability
☐ Posttraumatic stress disorder
☐ Cognitive impairments resulting from brain injury
☐ Chronic physical illness or disability
☐ **None of the above**

Parental Status (Check all that apply)	Primary Language at Home	Referred by Child Welfare Agency (DCFS)	Receiving SNAP (food stamps)	Receiving WIC
☐ Two parent household ☐ Single parent ☐ Parent lives with a partner ☐ Parents are divorced/separated ☐ Blended/Step family ☐ Foster Family ☐ Child lives with other relatives ☐ Other: _____	_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Type of services family is currently receiving **(mark all that apply)** ☐ **No services received**

☐ Child support/alimony
☐ Unemployment benefits
☐ Medicaid/Medicare
☐ CHIP
☐ TANF/FEP (cash assistance)
☐ Public housing
☐ HEAT (home energy assistance program)
☐ Foster care
☐ Kinship assistance
☐ Adoption subsidy
☐ SSI (Supplemental Security Income)
☐ SSA/SSDI/SS
☐ Child Care Assistance
☐ Refugee Assistance
☐ Applicant (child) receiving special needs/disability services
☐ Other (please list): _____

Family circumstances within the immediate household **(mark all that apply)** ☐ **Not applicable**

☐ Family member with disability/special need
☐ Family member with medical issue
☐ Family member with mental illness
☐ Loss of family member through separation
☐ Loss of family member through divorce
☐ Loss of family member through death
☐ Current high risk pregnancy
☐ Early intervention
☐ Oldest child was born when parent (mother or father) was under 18 years of age
☐ Substance abuse/treatment
☐ Incarcerated family member
☐ Domestic violence
☐ Abuse/neglect
☐ Child Protective Services involvement
☐ Restraining order

Special Needs Information

Special Needs Concerns

Do you have any concerns about your child? ☐ **Yes** ☐ **No**

If yes, mark in which area including date diagnosed by a professional (if applicable):

☐ Speech and language (in primary language) _____
☐ Emotional & behavioral concerns _____
☐ Ability to learn _____
☐ Physical impairment _____
☐ Health impairment _____
☐ Autism _____
☐ Traumatic brain injury _____
☐ Head injury/concussion _____
☐ Vision impairment (including blindness) _____
☐ Hearing impairment (including deafness) _____
☐ Other (please explain) _____

Please explain your concerns:_____
_____
_____

Special Education Services/Early Intervention

Has your child ever received special education services or early intervention? ☐ Yes ☐ No Do you have any special education documentation? ☐ Yes ☐ No ☐ **Not applicable**	Is your child on an Individualized Education Plan (IEP)? ☐ Yes ☐ No If yes, please write where the child was attending: _____	Is your child on an Individualized Family Service Plan (IFSP)? ☐ Yes ☐ No If yes, please write where the child was attending: _____

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

Is there a specialist, clinic or school district working with your child (example: The Children's Center, Primary Children's Hospital, etc.)? ☐ Yes ☐ No

Name of specialist, clinic or school district: _____

Location or address: _____

I understand that this is an application for services that are paid for with federal government funds and that intentionally providing misleading, inaccurate or untruthful information may result in my child being terminated from the Head Start/Early Head Start program.

Parent/guardian signature: _____ Date: _____

Parent/guardian name (printed): _____

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Health & Nutrition History

Please fill out completely. All the information will be kept confidential.

Child's name: _____ **Date of birth:** _____

1. Does your child take any medications regularly? ☐ Yes ☐ No

   If yes, what? _____

   Does the above listed medication need to be administered during school hours? ☐ Yes ☐ No

2. Does your child have any known allergies and/or sensitivities to food, medications, insects, etc?

   ☐ Yes ☐ No If yes, please explain: _____

3. Do you have dietary needs that are based on cultural, religious, ethical or personal preferences?

   ☐ Yes ☐ No If yes, please explain: _____

4. Is your child on a special diet due to medical needs? ☐ Yes ☐ No

   If yes, please explain: _____

5. Is your child toilet trained? ☐ Yes ☐ No

   If no, what size diapers does your child wear (Head Start will provide) Size:_____

6. Does your child take a bottle or a sippy cup? ☐ Yes ☐ No If yes, specify which one: _____

7. Does your child eat or chew things that are not food? ☐ Yes ☐ No

   If yes, please explain: _____

8. Does your child have trouble chewing or swallowing? ☐ Yes ☐ No

9. Has your child ever gone to the dentist? ☐ Yes ☐ No

10. Does your child currently have any decayed teeth? ☐ Yes ☐ No

11. Does your child participate regularly in physical activity? ☐ Yes ☐ No

12. Is there a reason to limit your child's physical activity? ☐ Yes ☐ No

    If yes, please explain: _____

13. Has your child had any of the following health problems and/or acute chronic medical conditions? (mark all that apply)

☐ Asthma
☐ Diabetes
☐ Seizures/epilepsy
☐ Bone/muscle deformity
☐ Chronic earaches/tubes
☐ Frequent sore throat
☐ Vision problem/glasses
☐ Frequent bruising/bleeding
☐ Poor appetite
☐ Mental Health
☐ Other (please specify):

☐ **None of the above**

14. Is there any additional health information or special instructions that we need to be aware of?

    ☐ Yes ☐ No If yes, please explain: _____

    _____

Medical/Dental Home Information

15. Do you have medical insurance for your child? ☐ Yes ☐ No

If yes, which type of insurance does your child have? ☐ Medicaid ☐ CHIP ☐ Private

If you have Medicaid, what is the I.D. number? Medicaid ID number: _____

16. Does your child have a doctor or health clinic? ☐ Yes ☐ No

Name of doctor/clinic: _____ Phone number: _____

Address: _____

17. Do you have dental insurance for your child? ☐ Yes ☐ No

If yes, which type of insurance does your child have? ☐ Medicaid ☐ CHIP ☐ Private

18. Does your child have a dentist or dental clinic? ☐ Yes ☐ No

Name of dentist/clinic: _____ Phone number: _____

Address: _____

Lead Risk Assessment

1. Within the past 12 months, have you lived in a house or apartment built before 1950?
   ☐ Yes ☐ No

2. Does your child regularly spend time in a home or building that was built before 1950?
   ☐ Yes ☐ No

3. Does your child live in a house/building built before 1978, with peeling or chipping paint, or ongoing renovation or remodeling within the last 12 months?
   ☐ Yes ☐ No

4. Does anyone in your home have a hobby or a job that may involve lead? For example: fishing (lead sinkers), target shooting, ceramics/pottery, making stained glass windows, construction, painting, mechanic/auto repair, working with radiators and/or batteries, etc.
   ☐ Yes ☐ No

Second year students only: ☐ N/A

If you have answered *yes* to any of these questions, your child is considered to be at risk for lead exposure and will be tested when the child enters the program.

5. Have you moved within the last 12 months?
   ☐ Yes ☐ No

6. If yes, was this resident built before 1950?
   ☐ Yes ☐ No ☐ N/A

Tuberculosis Questionnaire

This questionnaire concerns any person living in the household where the child resides.

1. Has anyone currently living in the household left the country in the last 3 months? ☐ Yes ☐ No

2. Has anyone currently living in the household had a positive TB test? ☐ Yes ☐ No (if *No*, skip to question)

   If yes, was an x-ray done? ☐ Yes ☐ No

   If yes, what were the results of the x-ray? ☐ Positive ☐ Negative

   If positive, was medication prescribed for you? ☐ Yes ☐ No

   Did you complete treatment? ☐ Yes ☐ No ☐ Still in treatment

3. Do you or anyone living in the household currently have any of the following symptoms that cannot be explained?

- **Unexplained** fatigue (tiredness) longer than 3 weeks ☐ Yes ☐ No
- **Unexplained** weight loss ☐ Yes ☐ No
- **Unexplained** fever (usually at night) ☐ Yes ☐ No
- **Unexplained** Night sweats (drenching) ☐ Yes ☐ No
- **Unexplained** Cough for more than 3 weeks (not related to chronic lung disease or viral upper respiratory infection) ☐ Yes ☐ No
- Hemoptysis (coughing up blood) ☐ Yes ☐ No
- Been exposed to anyone with TB in the past 12 months ☐ Yes ☐ No

If you answered "Yes" to any of the above questions, please explain:_____

_____

_____

_____

_____

_____

To be completed a member of the Health and Family Partnership team (Heath Specialist, FA/SS):

Reviewed by: _____ Date: _____

Action taken (if necessary): _____

Consents and Permissions

I give permission for the following screenings to be conducted on my child at Head Start or Early Head Start: **Please mark with an X**

Vision	Yes _____	No _____
Hearing	Yes _____	No _____
Height & weight	Yes _____	No _____
Hematocrit/hemoglobin	Yes _____	No _____
Lead screening	Yes _____	No _____
Blood pressure	Yes _____	No _____
Dental Exam (with fluoride application)	Yes _____	No _____
Health Exam	Yes _____	No _____
Developmental & Speech screening	Yes _____	No _____
Mental Health	Yes _____	No _____
My child may go on walking field trips with his/her class.	Yes _____	No _____
My child's photograph/video can be used in his/her classroom.	Yes _____	No _____
My child's photograph/video can be used in the newspaper, pamphlets, television, internet, website (Promotional Purposes)	Yes _____	No _____
My child's health records can be shared with the school system and/or WIC	Yes _____	No _____
Head Start can share my child's contact information for kindergarten placement.	Yes _____	No _____
Head Start can share my child's educational records, as needed, with the local school district or early intervention program.	Yes _____	No _____

*** The medical history information that I have provided is accurate and true to the best of my knowledge.**

Parent/guardian signature: _____ Date: _____

Parent/guardian name (printed): _____

Salt Lake Head Start Classroom Locations

(We will try to accommodate your 1st choice, but it is not guaranteed)

General Hours - AM 8:00-11:30 PM 12:30-4:00 pm Extended day 7:30-4:00 * Extended day is Tuition based**

Please mark 1st & 2nd choice **Classrooms Sandy/Midvale/Murray Areas** **Please circle session choice**

	Bellview	9800 South 800 East, Sandy 84070	AM or PM
	Midvalley	217 East 7800 South, Midvale 84047	AM or PM
	Copperview	8446 South Harrison (300 W.), Midvale 84047	AM or PM
	Midvale Boys and Girls Club	7631 South Chaplet St (423 W) Midvale 84047	AM or PM
	Murray	73 West 6100 South, Murray 84107	AM or PM

Please mark 1st & 2nd choice **Classrooms West Jordan/Riverton Areas** **Please circle session choice**

	Majestic	7450 South 1700 West, West Jordan 84084	AM or PM
	West Jordan	7220 South 2370 West, West Jordan 84084	AM or PM
	Terra Linda	8400 South 3400 West, West Jordan 84088	AM or PM
	Rose Creek	3600 West 12812 South, Riverton 84065	AM or PM
	Riverton	12891 South Redwood Road, Riverton 84065	AM or PM

Please mark 1st & 2nd choice **Classrooms West Valley (west)/Magna Area** **Please circle session choice**

	Cathy C. Hoskins	6447 West 4100 South, West Valley 84128	AM or PM
	Magna	8275 West 3500 South, Magna 84044	AM or PM

Please mark 1st & 2nd choice **Classrooms Kearns Area** **Please circle session choice**

	Oquirrh Hills	5241 South 4245 West, Kearns 84118	AM or PM
	South Kearns	4430 West 5570 South, Kearns 84118	AM or PM
	West Kearns	4900 South 4620 West, Kearns 84118	AM or PM

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General Hours - am 8:00-11:30 pm 12:30-4:00 pm Extended day – 7:30-4:00 * Extended day is Tuition based**

Please mark 1st & 2nd choice **Classrooms Taylorsville/West Valley (east) Areas** **Please circle session choice**

	Salt Lake Community College	4626 South Redwood Road, Taylorsville 84123	AM or PM
	Stansbury	3050 South 2799 West, West Valley, 84119	AM or PM
	Monroe	4450 West 3100 South, West Valley, 84120	AM or PM
	Redwood	3060 S. Lester St. (1595 W.), WVC 84119	AM or PM

Please mark 1st & 2nd choice **Classrooms South Area** **Please circle session choice**

	Hal J. Schultz	336 East 3900 South, SLC 84115	AM or PM
	South Salt Lake	2825 South 200 East, SLC 84115	AM or PM
	Creek Side	254 East 3020 South, SLC 84115	AM only

Please mark 1st & 2nd choice **Classrooms North Area** **Please circle session choice**

	James R. Russell	1240 North American Beauty (1065 W.), SLC 84116	AM or PM / Extended day***
	Horizonte	1234 South Main SLC, 84104	AM or PM / Extended day***
	Shriver	1307 South 900 West, SLC 84104	AM or PM
	Neighborhood House	1050 West 500 South, SLC 84014	AM or PM

Please mark 1st & 2nd choice **Classroom Tooele/Wendover Areas** **Please circle session choice**

	Tooele	222 North Coleman, Tooele 84074	AM or PM
	Grantsville	7 South Park St., Grantsville 84029	AM only
	Wendover	1007 Skyhawk, Wendover 84083	AM or PM

Please mark 1st & 2nd choice **Classroom Partner** **Please circle session choice**

	University of Utah	1945 E. Sunnyside Ave., (West Village Child Care) SLC 84108	AM or PM

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