

**NORTHEAST SOUTH DAKOTA HEAD START PROGRAM, INC.**  
**200 S Harrison St #1, Aberdeen, SD 57401 (605-229-4506)**  
**2020-2021 FAMILY/CHILD ENROLLMENT APPLICATION**

<b>Applicant 1</b>	<b>First</b>	<b>M</b>	<b>Last</b>	<b>Birthday:</b>	<input type="checkbox"/> Female <input type="checkbox"/> Male
<b>Race</b> <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other: _____		<b>Hispanic</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>English Proficiency</b> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> Proficient  <input type="checkbox"/> Primary Language	<b>Other Language</b>	<b>Other Language Proficiency</b> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> Proficient  <input type="checkbox"/> Primary Language
<b>Medicaid</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Private Health Insurance</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Dental Insurance</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Doctor:</b>  <b>City/State:</b>		<b>Dentist:</b>  <b>City/State:</b>
<b>Diagnosed Disability</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Please Explain Disability:</b>	<b>IEP</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Food Allergy</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Please Explain Food Allergy:</b>	

<b>Applicant 2</b>	<b>First</b>	<b>M</b>	<b>Last</b>	<b>Birthday:</b>	<input type="checkbox"/> Female <input type="checkbox"/> Male
<b>Race</b> <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other: _____		<b>Hispanic</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>English Proficiency</b> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> Proficient  <input type="checkbox"/> Primary Language	<b>Other Language</b>	<b>Other Language Proficiency</b> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> Proficient  <input type="checkbox"/> Primary Language
<b>Medicaid</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Private Health Insurance</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Dental Insurance</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Doctor:</b>  <b>City/State:</b>		<b>Dentist:</b>  <b>City/State:</b>
<b>Diagnosed Disability</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Please Explain Disability:</b>	<b>IEP</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Food Allergy</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Please Explain Food Allergy:</b>	

<b>Primary Adult</b>	<b>First</b>	<b>M</b>	<b>Last</b>	<b>Birthday:</b>	<input type="checkbox"/> Female <input type="checkbox"/> Male
<b>Race</b> <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other: _____		<b>Hispanic</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>English Proficiency</b> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> Proficient	<b>Other Language</b>	<b>Other Language Proficiency</b> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> Proficient
<b>Highest Grade Completed</b> <input type="checkbox"/> Associate's <input type="checkbox"/> Grade 10 <input type="checkbox"/> Bachelor's <input type="checkbox"/> Grade 11 <input type="checkbox"/> Master's <input type="checkbox"/> HS Diploma <input type="checkbox"/> Some College <input type="checkbox"/> <Grade 9 <input type="checkbox"/> GED <input type="checkbox"/> No Schooling	<b>Employment Status</b> <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired or Disabled <input type="checkbox"/> In School	<b>Child's Relationship</b> <input type="checkbox"/> Biological/Adopted/Step <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Relative <input type="checkbox"/> Foster <input type="checkbox"/> Other _____	<b>Custody</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Check all that apply:</b> <input type="checkbox"/> Lives with Family <input type="checkbox"/> Provides Financial Support  <b>Email Address:</b> _____	

<b>Secondary Adult</b>	<b>First</b>	<b>M</b>	<b>Last</b>	<b>Birthday:</b>	<input type="checkbox"/> Female <input type="checkbox"/> Male
<b>Race</b> <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other: _____		<b>Hispanic</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>English Proficiency</b> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> Proficient	<b>Other Language</b>	<b>Other Language Proficiency</b> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> Proficient
<b>Highest Grade Completed</b> <input type="checkbox"/> Associate's <input type="checkbox"/> Grade 10 <input type="checkbox"/> Bachelor's <input type="checkbox"/> Grade 11 <input type="checkbox"/> Master's <input type="checkbox"/> HS Diploma <input type="checkbox"/> Some College <input type="checkbox"/> <Grade 9 <input type="checkbox"/> GED <input type="checkbox"/> No Schooling	<b>Employment Status</b> <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired or Disabled <input type="checkbox"/> In School	<b>Child's Relationship</b> <input type="checkbox"/> Biological/Adopted/Step <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Relative <input type="checkbox"/> Foster <input type="checkbox"/> Other _____	<b>Custody</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Check all that apply:</b> <input type="checkbox"/> Lives with Family <input type="checkbox"/> Provides Financial Support  <b>Email Address:</b> _____	

**Other Family Members Supported by the Income of the Parent(s) or Guardian(s)**

Adult/Child	First	M	Last	Birthdate	Gender

**General Information**

<b>Living Address</b>	City	State	Zip Code	County
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<b>Mailing Address (If Different)</b>	City	State	Zip Code
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Phone Numbers	Opt in for Text Messages	Primary	Secondary	Notes:
Cell- ( )	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	
Cell- ( )	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	
Home- ( )		<input type="checkbox"/>	<input type="checkbox"/>	
Work- ( )		<input type="checkbox"/>	<input type="checkbox"/>	Work Place:

**Number in the household:** \_\_\_\_\_ **Number in the family supported by the Parent(s) / Guardian(s) income:** \_\_\_\_\_

<b>Parental Status</b> <input type="checkbox"/> One <input type="checkbox"/> Two	<b>Active Duty Military</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Military Veteran</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Primary Language at Home:</b>	<b>Requested Location</b> <input type="checkbox"/> Center _____ <input type="checkbox"/> Home Base _____
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**Day Care Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

In the event the Parent(s)/Guardian(s) cannot be reached by telephone concerning the Health/Safety of a child(ren), the emergency contact person will be notified to assist in the Health/Safety of the child(ren).

**Emergency Contacts (Other than Parent(s)/Guardian(s))**

Contact 1	Name:	Relationship to Child:	<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Release Child to
	Cell Phone:	Home Phone:	
Contact 2	Name:	Relationship to Child:	<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Release Child to
	Cell Phone:	Home Phone:	

**Family Information**

<b>TANF</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>SNAP</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Receive Regular Court Ordered Child Support</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>WIC</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Foster Child</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Homeless</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Referred</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>SSI</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			<b>Refer to WIC</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			<b>Referral Agency:</b>

**This Section to be Filled Out With the Parent/Guardian and Head Start Staff**

Family Member	Annual Amount	Type <sup>1</sup>	Desc. <sup>2</sup>	Verif. <sup>3</sup>

1. Type Codes			2. Description Codes		3. Verification Codes			
ERN—Earned TANF	FG—Financial Grant FC—Foster Care	CS—Child Support SSA or SSI	PEN—Pension SS—Social Security	SSI—SSI	CS—Check Stub TAN—TANF	W2—W-2 TAX-1040 Tax Form	EL—Employer Letter	DOC—Document CPA – Letter from Accountant

Income Check List:	Income Notes:
___ W-2 ___ 1040 Income Tax ___ Recent Pay Stubs ___ Certified Public Accountant ___ Court Ordered Child Support ___ Financial Aid Grant/Scholarships ___ Disability Documentation ___ SSI Documentation ___ Social Security Benefits ___ TANF Documentation ___ Foster Care Documentation ___ Written Statement/Third Party Statement ___ Other  **Tax 1040 and W-2 forms may only be taken up until July 1st of the applying year, then recent paystubs or employment letters must be taken after July 1st**	

**If family has ZERO income, please explain how family is meeting their basic needs.**

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The NESD Head Start Program, Inc. does not discriminate on the basis of race, color, national origin, age or disability in admission or access to, or treatment of employment in its programs and activities. The Section 504 Coordinator is the Human Resource/Technology Manager.

I certify that all information I have provided is true and correct, and that all income is reported. I understand that this information is being given to determine eligibility and will be verified for accuracy. If any part is false, my participation with the Northeast South Dakota Head Start Program may be terminated. I understand that the information I provided in this application will be held in strict confidence.

**\*I understand that completing this application does not guarantee my child’s enrollment into the program\***

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

How did you hear about us?  Newspaper  Radio  Friends/Family  Social Media  Flyers  Other \_\_\_\_\_

**In-Person Interview** \_\_\_\_\_ **Telephone Interview** \_\_\_\_\_

Please state the reason an in-person interview was not possible \_\_\_\_\_

**Staff Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



200 South Harrison Street #1  
Aberdeen, South Dakota 57401  
P: 605.229.4506 F: 605.226.0196

### General Release of Information

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Site: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Telephone: (home) \_\_\_\_\_ Ext. \_\_\_\_\_ (work) \_\_\_\_\_ Ext. \_\_\_\_\_

Address: Street/City/State/Zip: \_\_\_\_\_

I hereby request and authorize the below named agency to engage in verbal and/or written communication with and release records to the Northeast South Dakota Head Start Program, Inc., regarding the information checked below and any relative information regarding my child.

I understand that the purpose of releasing this information is to help staff better understand my child's strengths and needs and to help both agencies in order to facilitate transitions, follow-up and consistency in providing services to my child and our family.

- Developmental Screening (i.e. DIAL, Battelle, etc.)  Other \_\_\_\_\_  
 Evaluation Results – Special Education Assessments  Other \_\_\_\_\_  
 IEP

Agencies:

<u>Agencies:</u>	<u>Address /Street/City/State/Zip</u>	<u>Phone Number</u>

**\*Providers\*** Please send a copy of your findings to the above address or fax number.

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date)

This Release of Information is intended to follow all rules set forth by applicable IDEA, FERPA and HIPPA laws. Granting of this consent is voluntary on the part of the parent and may be revoked at any time. If revoked, that revocation is not retroactive and therefore it does not apply to an action that occurred before the consent was revoked. This release is in effect for one year from the date of the signature. It is understood a photocopy of this form will also serve as authorization.

Revised 12/18