

NORTHEAST SOUTH DAKOTA HEAD START PROGRAM, INC.
200 S Harrison St #1, Aberdeen, SD 57401 (605-229-4506)
2022-2023 FAMILY/CHILD ENROLLMENT APPLICATION

Applicant 1	First	M	Last	Birthday:	<input type="checkbox"/> Female <input type="checkbox"/> Male
Race <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: _____		Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No	English Proficiency <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> Proficient <input type="checkbox"/> Primary Language	Other Language	Other Language Proficiency <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> Proficient <input type="checkbox"/> Primary Language
Medicaid <input type="checkbox"/> Yes <input type="checkbox"/> No		Private Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No		Dental Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	
			Doctor: City/State:		Dentist: City/State:
Diagnosed Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	Please Explain Disability:		IEP <input type="checkbox"/> Yes <input type="checkbox"/> No	Food Allergy <input type="checkbox"/> Yes <input type="checkbox"/> No	Please Explain Food Allergy:

Applicant 2	First	M	Last	Birthday:	<input type="checkbox"/> Female <input type="checkbox"/> Male
Race <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: _____		Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No	English Proficiency <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> Proficient <input type="checkbox"/> Primary Language	Other Language	Other Language Proficiency <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> Proficient <input type="checkbox"/> Primary Language
Medicaid <input type="checkbox"/> Yes <input type="checkbox"/> No		Private Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No		Dental Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	
			Doctor: City/State:		Dentist: City/State:
Diagnosed Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	Please Explain Disability:		IEP <input type="checkbox"/> Yes <input type="checkbox"/> No	Food Allergy <input type="checkbox"/> Yes <input type="checkbox"/> No	Please Explain Food Allergy:

Primary Adult	First	M	Last	Birthday:	<input type="checkbox"/> Female <input type="checkbox"/> Male
Race <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: _____		Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No	English Proficiency <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> Proficient <input type="checkbox"/> Primary Language	Other Language	Other Language Proficiency <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> Proficient <input type="checkbox"/> Primary Language
Highest Grade Completed <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		Employment Status <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		Child's Relationship <input type="checkbox"/> Biological/Adopted/Step <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Relative <input type="checkbox"/> Foster <input type="checkbox"/> Other _____	Custody <input type="checkbox"/> Yes <input type="checkbox"/> No
Check all that apply: <input type="checkbox"/> Lives with Family <input type="checkbox"/> Provides Financial Support Email Address: _____					

Secondary Adult	First	M	Last	Birthday:	<input type="checkbox"/> Female <input type="checkbox"/> Male
Race <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: _____		Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No	English Proficiency <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> Proficient <input type="checkbox"/> Primary Language	Other Language	Other Language Proficiency <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> Proficient <input type="checkbox"/> Primary Language
Highest Grade Completed <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		Employment Status <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		Child's Relationship <input type="checkbox"/> Biological/Adopted/Step <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Relative <input type="checkbox"/> Foster <input type="checkbox"/> Other _____	Custody <input type="checkbox"/> Yes <input type="checkbox"/> No
Check all that apply: <input type="checkbox"/> Lives with Family <input type="checkbox"/> Provides Financial Support Email Address: _____					

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

Adult/Child	First	M	Last	Birthdate	Gender

General Information

Living Address	City	State	Zip Code	County
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Mailing Address (If Different)	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:** _____

Parental Status <input type="checkbox"/> One <input type="checkbox"/> Two	Active Duty Military <input type="checkbox"/> Yes <input type="checkbox"/> No	Military Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Language at Home:	Requested Location <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

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

Family Member	Annual Amount	Type ¹	Desc. ²	Verif. ³

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	

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

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.)
- Evaluation Results – Special Education Assessments
- IEP
- Other _____
- Other _____

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 of Signature)

Authorization Valid Through _____
 (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 until the date listed or for one year from the date of the signature (whichever is longer). It is understood a photocopy of this form will also serve as authorization.