Semcac Head Start/Early Head Start Application

P.O. Box 549, Rushford MN 55971 Toll Free#: 1-866-808-0260 Telephone#: 507/864-7741 Fax #: 507/864-2440

Please fill out front and back of the application; sign and date. Please print clearly. If you need help, please call.

This Institution is an Equal Opportunity Provider

Program Options		
Program term applying to: ☐ 2023-2024 ☐ 2024-2025		
Location you're applying to: ☐ Austin ☐ Eagle Bluff ☐ LaCrescent ☐ LeRoy ☐ Kasson ☐ Owatonna ☐ Spring Grove ☐St. Charles ☐ Winona		
Name of Person in case we cannot contact you:	Name:	Phone Number

Family Information			
Living Address:		**Mailing address (if different):**	
City:	**State:**	**Zip Code:**	**County:**
Housing Arrangements: ☐ Rent ☐ Own ☐ Shelter ☐ Homeless ☐ Other: _____			
Primary Language at Home :		**Interpreter needed:** ☐ Adult ☐ Child ☐Not Applicable	
Marital Status: ☐Single ☐Single, living with Partner ☐Married ☐Separated ☐Divorced ☐Widowed			

Primary Parent/Caregiver		
Legal First Name:	**Legal Last Name:**	**Relationship to Child:**
Preferred First Name (if different):	**Preferred Last Name (if different):**	**Gender:** ☐ Female ☐ Male ☐ Nonbinary
Date of Birth:	**Cell Phone:** **Can we text you?** ☐ Yes ☐No	**Email:**
Race: ☐ American Indian/Alaska Native ☐ Asian ☐Black/African American ☐Multi-Racial ☐Native Hawaiian/Pacific Islander ☐White ☐Other: _____		**Ethnicity:** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino
Employment Status: ☐ Full-Time ☐ Part-Time ☐ Seasonal ☐ Retired/Disabled ☐ Training/School ☐ Unemployed ☐Maternity Leave		
Highest Level of Education: ☐ Less than High School Graduate ☐ High School Graduate ☐ General Education Diploma ☐ Some College ☐Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree		
Insurance Type (check all that apply): ☐ Medicaid ☐ Medicare ☐ Minnesota Care ☐ Private ☐ None ** explain insurances		

Secondary Parent/Caregiver (if applicable)		
Legal First Name:	**Legal Last Name:**	**Relationship to Child:**
Preferred First Name (if different):	**Preferred Last Name (if different):**	**Gender:** ☐ Female ☐ Male ☐ Nonbinary
Date of Birth:	**Cell Phone:** **Can we text you?** ☐ Yes ☐No	**Email:**
Race: ☐ American Indian/Alaska Native ☐ Asian ☐Black/African American ☐Multi-Racial ☐Native Hawaiian/Pacific Islander ☐White ☐Other: _____		**Ethnicity:** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino
Employment Status: ☐ Full-Time ☐ Part-Time ☐ Seasonal ☐ Retired/Disabled ☐ Training/School ☐ Unemployed ☐Maternity Leave		
Highest Level of Education: ☐ Less than High School Graduate ☐ High School Graduate ☐ General Education Diploma ☐ Some College ☐Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree		
Insurance Type (check all that apply): ☐ Medicaid ☐ Medicare ☐ Minnesota Care ☐ Private ☐ None ** explain insurances		

Additional people living in the home *please attach another piece of paper if you need more space*						
First and Last Name	**Date of Birth**	**Gender**	**Race** (See legend below)	**Ethnicity: Hispanic/ Latino**	**Relationship to Primary Caregiver**	**Relationship to Secondary Caregiver**
1.		☐ Male ☐ Female ☐ Nonbinary		☐ Yes ☐ No		
2.		☐ Male ☐ Female ☐ Nonbinary		☐ Yes ☐ No		
3.		☐ Male ☐ Female ☐ Nonbinary		☐ Yes ☐ No		
4.		☐ Male ☐ Female ☐ Nonbinary		☐ Yes ☐ No		
5.		☐ Male ☐ Female ☐ Nonbinary		☐ Yes ☐ No		
6.		☐ Male ☐ Female ☐ Nonbinary		☐ Yes ☐ No		
Is anyone in the home pregnant? ☐ Yes ☐ No If yes, who? _____ Due Date:_____						
RACE: AI/AN = American Indian/Alaska Native A = Asian B/AA = Black/African American M = Multi-Racial NH/PI = Native Hawaiian/Pacific Islander W = White O = Other: Specify						
RELATIONSHIP TO PRIMARY/SECONDARY CAREGIVER: Birth Child -- Step Child -- Foster Child -- Adopted Child -- Other Relative Legal Guardian -- Not Related						

Do any of the following apply to your family? (check all that apply)	
☐ Homeless	☐ No caregiver present because parent(s) working and/or in job training/education for 6hrs or more per day
☐ Foster Care	☐ WIC
☐ First time parent	☐ No health insurance for the child
☐ Current teen parent	☐ No health insurance for the parent/caregiver
☐ Incarcerated parent	☐ Family's home language is not English
☐ Death of child's parent	☐ Refugee camp – within last 5 years
☐ Death of child's sibling	☐ Active/Veteran for US military
☐ Experienced a pregnancy loss	☐ Family previously enrolled in a EHS/HS program
☐ Family with 3 or more under the age of 5	☐Over income returning child
☐ Household member with special needs	☐ Current or history of domestic violence
☐ Household member with mental health concerns	☐ Current or history of drug/alcohol abuse
☐ Documented public school, community agency, or health professional referral	
Are any of the applicants listed CURRENTLY enrolled in EHS? ☐ Yes ☐ No If yes, name/where_____	
Do any of the Applicants have a <u>chronic health problem, allergy, intolerance</u>? If so, list applying child names and the health problem. ☐ Yes ☐ No Explain: _____	
Do any of the Applicants have an: ☐IEP ☐IFSP ☐Social Emotional Concern ☐ Speech Concern ☐ Development Concern ☐ Other: _____	

Program Options (check all that apply)						
Early Head Start Home-based (Pregnant Women and Birth to 3)/Center based (2 year olds):						
Austin/Mower County ☐ Mower county Home-based ☐ Austin Toddler room		**Houston/Fillmore** ☐ Home-based			**Winona County** ☐ Home-based ☐ Winona Toddler Room	
Head Start (3-5 year olds):						
☐ Austin **☐ LeRoy**	**☐ Eagle Bluff**	**☐ LaCrescent**	**☐ Kasson**	**☐ Owatonna**	**☐ Spring Grove**	**☐ St. Charles** **☐ Winona**

Family Income: (check all that apply)
**** All income MUST be from the same 12 month time period**

☐ MFIP/TANF (must show currently on)
☐ SNAP (must show currently on)
☐ SSI – Supplemental (must show currently on)
☐ 1040 (previous year)
☐ W2(s) (previous year)
☐ Child Support (previous year)
☐ Unemployment (previous year)
☐ Pay Stubs (12 months)
☐ Income Self Declaration Form
☐ Homeless/McKinney-Vento Act Questionnaire
☐ Foster Care: Court Documents
☐ SSI for Disability
☐ Other: _____

TOTAL GROSS INCOME:_____

FAMILY

For the purposes of eligibility, *Family*, for a child, means all persons living in the same household who are:

(1) Supported by the child's parent(s) or guardian(s)' income; and
(2) Related to the child's parent(s) or guardian(s) by blood, marriage or adoption; or
(3) The child's authorized caregiver or legally responsible party.

Family, for a pregnant woman, means all persons who financially support the pregnant woman.

Who referred you or how did you learn about our program? (check all that apply)

☐ Child Care Program
☐ Early Childhood Screening
☐ Health Care Provider
☐ Semcac Website
☐ Parade
☐ Social/Human Service Agency
☐ Family or Friend
☐ Word of Mouth
☐ Brochure or Poster
☐ Fair
☐ Adult Basic Ed or other Adult Literacy Program
☐ Early Childhood Special Education
☐Parent or Sibling previously attended
☐ Other: _____

** Thank you for this information. It helps in our recruitment efforts to reach families most in need.

1. I have received a copy of "Semcac Data Privacy Notice". ☐ Yes ☐ No
2. I give permission for Head Start to release my child/children's name, parent(s) name, phone number and address to his/her local school district and to ☐ Release ☐ Obtain preschool screening records (child/children's Name) _____ ☐ Yes ☐ No
3. I understand by completing this application it does not guarantee my child will be accepted into the program. ☐ Yes ☐ No
4. A copy of the applying child /children's Immunization record or Birth Certificate is attached. ☐ Yes ☐ No
5. If you are not eligible for Head Start may we share your application with other Childcare Programs in our area that you may qualify for? ☐ Yes ☐ No

The information provided is accurate and true. I give Semcac Head Start permission to verify all of the above information. I further understand that Head Start is a service paid for with federal and state funds and providing inaccurate, misleading, or untruthful information could have serious legal consequences for me.

Parent/Guardian Signature _____ Date _____
If signer is not biological mother or father, ***attach completed Delegation of Powers by Parent form.***

I have reviewed the above application and verified the Family's Income.

Staff Signature _____ Date _____

Notes: