Iowa Tribe of Oklahoma
Early Head Start & Child Care Application
2021-2022 Application

335588 E.750 Rd.
Perkins, Oklahoma 74059
(405) 547-5826
Fax: (405) 547- 5991

Thank you for your interest in the Iowa Tribe of Oklahoma Early Head Start. In order for us to determine eligibility, all information needs to be complete to the best of your ability and the information listed below needs to be attached. You will then be notified in writing if a slot is available for your child or further information is needed.

Set Selection Criteria will be used when determining enrollment priority of infants and toddlers. When filling a slot, the age of the child to be selected is determined by the vacancy of the 'age group' for center-based services.

Be sure all necessary documentation is enclosed before application is submitted

1. Iowa Tribe of Oklahoma Early Head Start Application
2. Copy of the child/parent CDIB card
3. Copy of child's state-issued birth certificate or the hospital
4. Copy of child's up-to-date immunization record
5. Income verification
   - ▫Recent income for a month period (for review only)
   - ▫1040 Income Tax
   - ▫Public assistance award letter
   - ▫Verification of wages and hours worked from employer
   - ▫SSI documentation
6. Payment contract and verification of child care assistance
7. Copy of parent work or school schedule
8. Insurance card (If Applicable)
   - ▫Medicaid
   - ▫United Health Care
   - ▫Blue Cross Blue Shield
   - ▫None
   - ▫Other ______________________________

ERSEA-003
Revised 6/3/2020

This institution is an equal opportunity Provider and Employee

Applicant & Family Member Information

Applicant

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ None		☐ Poor
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Little		☐ Moderate
☐ White	☐ Multi-Racial		☐ Moderate		☐ Proficient
☐ Other: ____________			☐ Proficient		

Primary Health Coverage	Other Health Coverage	Insurance #	Medicaid	Medicaid #	Doctor	Dentist
			☐ Not Eligible ☐ On Medicaid ☐ Potentially Eligible			

Adult 1

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ None		☐ Poor
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Little		☐ Moderate
☐ White	☐ Multi-Racial		☐ Moderate		☐ Proficient
☐ Other: ____________			☐ Proficient		

Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:
☐ Associate's	☐ Grade 10	☐ Full Time	☐ Full Time & Training	☐ Natural/Adopted/Step	☐ Yes	☐ Lives with Family
☐ Bachelor's	☐ Grade 11	☐ Part Time	☐ Part Time & Training	☐ Grandchild	☐ No	☐ Provides Financial Support
☐ Col Deg/Train	☐ Grade 12	☐ Seasonal	☐ Training or School	☐ Niece/Nephew		☐ Teen Parent
☐ Col or Adv Train	☐ < Grade 9	☐Unemployed	☐ Retired or Disabled	☐ Foster		
☐ GED	☐ HS Graduate			☐ Other		If teen parent, subsidized?
	☐ Master's					☐ Yes ☐ No

E-mail Address:

Adult 2

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ None		☐ Poor
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Little		☐ Moderate
☐ White	☐ Multi-Racial		☐ Moderate		☐ Proficient
☐ Other: ____________			☐ Proficient		

Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:
☐ Associate's	☐ Grade 10	☐ Full Time	☐ Full Time & Training	☐ Natural/Adopted/Step	☐ Yes	☐ Lives with Family
☐ Bachelor's	☐ Grade 11	☐ Part Time	☐ Part Time & Training	☐ Grandchild	☐ No	☐ Provides Financial Support
☐ Col Deg/Train	☐ Grade 12	☐ Seasonal	☐ Training or School	☐ Niece/Nephew		☐ Teen Parent
☐ Col or Adv Train	☐ < Grade 9	☐Unemployed	☐ Retired or Disabled	☐ Foster		
☐ GED	☐ HS Graduate			☐ Other		If teen parent, subsidized?
	☐ Master's					☐ Yes ☐ No

E-mail Address:

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ None		☐ Poor
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Little		☐ Moderate
☐ White	☐ Multi-Racial		☐ Moderate		☐ Proficient
☐ Other: ____________			☐ Proficient		

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ None		☐ Poor
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Little		☐ Moderate
☐ White	☐ Multi-Racial		☐ Moderate		☐ Proficient
☐ Other: ____________			☐ Proficient		

Family Information

Living Address	Address Line 2	Zip	City	State	County

Mailing Address (if different)	Address Line 2	Zip	City	State	County

Phone Numbers	Type (*check one*)	Note (*for example, an extension or best time to call*)
	☐ Cell ☐ Home ☐ Work ☐ Other	
	☐ Cell ☐ Home ☐ Work ☐ Other	
	☐ Cell ☐ Home ☐ Work ☐ Other	

Parental Status (check one)	Primary Language at Home	Homeless Family	Active Duty Military	Referred by Child Welfare Agency	Receiving SNAP	WIC	WIC ID (*if applicable*)
☐ One ☐ Two		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

Family Income

TANF	Supplemental Security Income
☐ Yes ☐ No ☐ Formerly	☐ Yes ☐ No

Date Verified *(agency use only)* Verified by *(agency use only)*

Family Member	*Amount*	*Per (for example: week, month, year)*	*Annual Amount*	*Description (for example: SSI, Job, Child Support)*	*Verification (for example: W2, check stub)*	*Notes*
	$		*$*			
	$		*$*			
	$		*$*			

Income Notes

Emergency Contacts

Contact 1

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Address	Zip	City	State

Phone # 1	Phone # 2	Phone # 3
☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work

Contact 2

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Address	Zip	City	State

Phone # 1	Phone # 2	Phone # 3
☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work

Contact 3

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Address	Zip	City	State

Phone # 1	Phone # 2	Phone # 3
☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work

Family Risk Factors

The next questions include topics that are more sensitive. Please share as much information as you are comfortable giving at this time. These are questions we ask of any family applying for our program. The more information you share with us, the better we can score your child's application.

All information in this application is kept confidential.

Do you have trouble meeting your child's basic needs such as housing, healthcare, and/or food? ❑ Yes ❑ No If yes, please explain:____.
Have you or your child witnessed alcohol or drug abuse in your household? ❑ Yes ❑ No If yes, please explain:____.
Has your child witnessed physical or verbal violence in your community? ❑ Yes ❑ No
Has your child witnessed physical or verbal violence in your home? ❑ Yes ❑ No
Are you homeless or live in a shelter? ❑ Yes ❑ No
Do you feel that your house and/or neighborhood are safe? ❑ Yes ❑ No
Have you had problems in the past with keeping a house or an apartment? ❑ Yes ❑ No
Does any family member living within your home have a documented disability? ❑ Yes ❑ No
Is this family member receiving SSI (Supplemental Security Income) for disability? ❑ Yes ❑ No
Does either parent have a mental illness? ❑ Yes ❑ No Is the parent receiving SSI for mental illness? ❑ Yes ❑ No
Has your child recently lost one of his/her parents due to death or imprisonment? ❑ Yes ❑ No
Or due to separation, divorce or abandonment? ❑ Yes ❑ No
Has your family ever been involved with Child Protective Services (CPS)? ❑ Yes ❑ No
Is there documented abuse or neglect? ❑ Yes ❑ No
Have you ever lost custody of your child? ❑ Yes ❑ No or voluntarily placed him or her in another home? ❑ Yes ❑ No
Do you or your child feel isolated; have little opportunity to interact with others? ❑ Yes ❑ No
Have there been any other serious events, which have put stress on your family recently? ❑ Yes ❑ No If so, please explain:____
Does your child have a sibling that is currently enrolled in Early Head Start or Head Start? ❑ Yes ❑ No
Does your child have a sibling that was previously enrolled in Early Head Start or Head Start? ❑ Yes ❑ No
Was either parent enrolled in Early Head Start or Head Start as a child? ❑ Yes ❑ No
What kind of transportation do you use? (my car, bus, family/neighbors, etc.):____________________________________

Are other community agencies providing services to you or anyone else living in your house? ☐ Yes ☐ No
If yes, please list below.

AGENCY	PERSON'S NAME

I am interested in...

- ☐ Expectant Families Program
- ☐ Early Head Start only (8am-2pm FREE)
- ☐ Center-based services (in a classroom)
- ☐ Preschool Program (3 & 4 year old classroom)
- ☐ Before & After School Program

Why do you want your child to be in Early Head Start?

☐ I need childcare to continue working _____hours per week.

☐ I need childcare to find a job.

☐ I need childcare to return to school/job training/other training (explain):______________________________________

☐ My current childcare arrangements are not meeting our needs. (explain):_____________________________________

☐ I want my child to spend time with other children.

☐ I would like parent education.

☐ Other:____

Will you be utilizing Early Head Start Hours (8-2 p.m.) or before and after care (please specify)? From: _____ To: _____

Please tell us how you found out about our program. This will help us understand the best ways to reach out to families in our community (check one):

☐ **Newspaper**

☐ **A posted flyer/sign I saw (where?):**____

☐ **From a friend/neighbor/family member** ____

☐ **From someone who works with the family (who?)**____

☐ **Other:** ____

Certification: *I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.*

Parent/Legal Guardian's Signature ________________________ Date _____/_____/_____

WHAT'S NEXT....

You will receive a letter to confirm the status of your application or an email with the confirmation attached if you wish for us to correspond via the internet. We will let you know if we need more information. We will need to be able to communicate with you as we determine your child's eligibility and possible placement in our program. **Please contact us if your address, income, phone number(s) or other family information changes**. If there is a friend/family member who can help us get in touch with you about the status of your application, please put his or her name(s) and phone number(s) below:

____ ______________________________

Parent (s) Name Email

Friends/Relative:

____ ______________________________

Name Phone Number

____ ______________________________

Name Phone Number

Iowa Tribe of Oklahoma Early Head Start

Application Consent for Exchange of Information

Child's Name:_______________________________________ Date of Birth:____/____/____

The Iowa Tribe of Oklahoma Early Head Start program operates in partnership with community agencies serving children and families. These partnerships help us to promote access to support programs for families who are eligible to receive them. Your consent for our program staff to discuss your child(s) needs with other agencies will help to ensure that our services to your family are efficient and unified with other services your family may receive.

NOTE: Eligibility for the Early Head Start program will not result in the loss of services you already receive.

We may need to exchange information contained in this application with the following:

- **Local Health Department**
- **Department of Social Services (DSS)--TANF, Day Care, Child Protective Services or Indian Child Welfare**
- **Oklahoma DHS--Subsidy**
- **WIC**
- **SoonerStart-Early Intervention**
- **Other(s) (Please Complete)____**

____

CONSENT TO EXCHANGE INFORMATION WITH CHILD'S HEALTH CARE PROVIDERS:
Please list your child's pediatricians and any other place your child is seen for health care or specialty care:

- **Doctor's Office/Health Care Center (please specify):____**
- **Other Health Care Provider (please specify):____**

I give my consent for the Iowa Tribe of Oklahoma Early Head Start program to exchange information with the agencies listed above. I understand that this consent is voluntary and is valid until my child is no longer enrolled in the Iowa Tribe of Oklahoma Early Head Start program, or until I cancel this release in writing. I understand that this page of my application may be faxed to the above agencies to show my consent for this release and I release all health care providers of any liability while corresponding using any method of communication for example by phone or by fax.

____ _____/_____/_____

Parent/Legal Guardian's Signature **Date**

Iowa Tribe of Oklahoma
Early Head Start & Expectant Families Program
Child/Family Housing Questionnaire

Your child may be eligible for additional services. Eligibility can be determined by completing this questionnaire.

1. Where are you and your family currently staying? *Check one box*

- ❑ Sharing the housing of another family (i.e., doubling-up) due to loss of housing, economic hardship or similar reason.
- ❑ Living in a motel, hotel, trailer park, or campground because we cannot afford or find affordable housing.
- ❑ Staying in an emergency or transitional shelter.
- ❑ Living in a vehicle of any kind; in an abandoned building, in a tent, or campground or substandard housing without running water/electricity; or in a park, bus or train station.
- ❑ Section 8 Housing
- ❑ Military Housing
- ❑ None of the above. Living in my own apartment/home that I rent or own.

2. Please check all the apply.

- ❑ Child is living with an adult that is not a parent or legal guardian.
- ❑ Child is awaiting foster care placement.
- ❑ None of the above. Child is my own child.

3. Please describe the child who "lacks a fixed, regular, and adequate nighttime residence."

Name of Child(ren) **First**	 **Middle**	 **Last**	**Male/Female**	**Date of Birth**

The undersigned certifies that the information provided above is accurate.

Print Parent/Guardian Name/Adult Caring For Child Signature Date

Address (if available) City State Zip Code

(Area Code) Phone Number (Your own or a family member/friend's through which we can reach you)

Early Head Start Use Only

EHS ERSEA: Based on the above information (where one or none of the *"None of the Above"* boxes are checked) and a brief interview with this family, I attest that to the best of my knowledge by the information provided to me the child is eligible for benefits.

Print ERSEA Signature **Date**