

Application Check Sheet

Child's Name: _____ Date: _____

A staff member completed the intake with the parent: _____

No in-person intake was completed with parent because:

No staff available: _____ application was mailed: _____ Another agency worked with parent: _____

Other: _____

A phone interview was completed by: _____ Date: _____

First Attempt: _____ Second Attempt: _____

Application data entered/updated in CIS: _____

Application data entered/updated in THO: _____

Application has both parent and staff signature and date: _____

Application has been pointed, signature and date: _____

Application is Complete and has income: _____

Staff Signature: _____ Date: _____

Notes:

HEAD START APPLICATIONS:

Please complete both forms attached (if not filled out completely the application will not be processed) and bring the following:

Head Start is a free preschool experience for income eligible families. In order for a Head Start application to be complete and processed and the child put on a waiting list, income verification is needed showing 12 months of income for parents listed in household. Below are different ways that income may be verified:

- Federal tax return forms for 2018
- Pay stubs for the last 12 months
- Printout from your employer on company letterhead
- SSI benefits - award letter, copy of monthly check, or bank statement if direct deposited
- Child Support/Alimony - printout
- Iowa Workforce - printout for the past 5 quarters
- FIP - printout showing any benefits for the previous 12 months including the signature date on the Head Start application.
- College Students - scholarships or grants
- Copy of VISA if unable to work.

Please note that whatever you mark for income on the application, you will need to provide documentation for.

Applications may be dropped off at any of our Head Start Locations or mailed to this location:

HACAP
1515 Hawkeye Drive
Hiawatha Iowa 52233
Att. Stacy King

APPLICATION COVER SHEET

(Must be complete and attached to all applications/files sent to Corporate for enrollment)

- **CHILD NAME:** _____ ● **DATE OF BIRTH:** _____
- **HACAP HOUSING:** Yes No ● **POINTS:** _____ ● **LEVEL:** _____
- **APPLICATION COMPLETED AT:** _____ ● **DATE:** _____
(location)
- **SITE REQUESTED (1ST Choice)** _____ **(2nd Choice)** _____
- **CURRENT SCHOOL DISTRICT** _____

FAMILY NEED (Circle One)	HS Full Day (10 hr.)	HS School Day (8 hr.)	HS Part Day (4 hr) Mon-Fri
	EHS Center Based (10 hr.)	EHS Home Based	

FILE STATUS:	<i>COMPLETE</i>	<i>INCOMPLETE</i>
● Complete Application	Date: _____	Needed
● Income Verification	Date: _____	Needed
● Physical	Date: _____	Needed
● Certificate of Immunization	Date: _____	Needed
● Disabilities (IEP or IFSP)*	Date: _____	Needed
*If Applicable		
● CACFP Application*	Date: _____	Needed
*Required for Over-income and Private Pay children		

ABBREVIATED NUTRITION ASSESSMENT – Must be completed at time of application

1. Parent concerns about child eating in the Head Start classroom?	Yes	No
2. Any special diet modifications child must follow? (i.e. medical diet, food allergies)	Yes	No
If yes, a Food Allergy/Special Medical Diet Form must be completed and sent to the CACFP Manager. Please complete and attach.		
3. Any religious dietary restrictions we should know about?	Yes	No
If yes, explain _____		
4. Are you participating in WIC?	Yes	No
If yes, when was the child's last certification? _____		
5. Are you able to provide adequate meals for your family?	Yes	No
(i.e. do you run out of food*, does your refrigerator/stove work?) *Encourage community resources as needed		

SPECIAL NEEDS – Must be completed at time of application

1. Suspected Disability	Yes	No
If yes, suspected disability reported by: _____		
2. Professionally Diagnosed Disability	Yes	No
If yes, describe: _____		
Disability professionally diagnosed by: _____		
Documented diagnosis/verification included with application	Yes	No
included with application?		
3. Special Health Concerns	Yes	No
If yes, describe: _____		

REVISED 4/19 s/forms/HS-EHSApplicationTime/Application/Application Cover Sheet.doc

Basic Intake Form – HS/EHS

Flag for Review
Red – Health
Blue – Disability
Yellow – Nutrition
Green – Other
ATTACH FLAG HERE →

Last Name _____ First Name _____ MI _____

Street Address _____ City _____ State _____ Zip _____

Mailing Address (if different) _____ City _____ State _____ Zip _____

Primary Phone # (home/cell) _____ Alternate Phone # (cell/work/message/emergency) _____

HOUSING: Own or Buying Renting Homeless (complete back page) Other explain _____ (complete back page)

FAMILY TYPE: Female single parent Male single parent Two parent Household

Total # of Household Members: _____ #of children _____ By age: 0-3 _____ 4-5 _____ CCBG Subsidy: applied _____ receiving _____

Native language if other than English: _____ Veteran in Family: _____ (indicate family member)

HOUSEHOLD MEMBERS (including yourself; If more than 5 members please continue on the back of this form)

	Name (first and last)	Relationship to Applicant	Date of Birth	Sex	Hispanic or Latino	Race	Ed. Level	Employment Status	Disability Y or N	Medical Insur.
Primary Adult					Yes No					
Secondary Adult or Child					Yes No					
Child					Yes No					
Child					Yes No					
Child					Yes No					

Education Level		Employment Status		Medical Insurance
COL-College/Advanced Training	G9-Grade 9 or less	F-Full Time (28+hrs/wk)	B-Full Time & Training	XIX Other
CTG-Training Cert.	G10-Grade 10	P-Part Time	L-Part Time & Training	Hawk-I Private
HSG-High School Grad	G11-Grade 11	R-Retired or Disabled	S-Seasonally Employed	None
GED-General Education Diploma	G12-Grade 12	T-Training or School	U-Unemployed	

INCOME SOURCES

****Proof of Income will be required to process application**

Income received in the last year (check all that apply)

	Primary Adult	Secondary Adult
Work	<input type="checkbox"/>	<input type="checkbox"/>
SSI	<input type="checkbox"/>	<input type="checkbox"/>
Social Security	<input type="checkbox"/>	<input type="checkbox"/>
FIP/TANF	<input type="checkbox"/>	<input type="checkbox"/>
Unemployment	<input type="checkbox"/>	<input type="checkbox"/>
Scholarships	<input type="checkbox"/>	<input type="checkbox"/>
Grants	<input type="checkbox"/>	<input type="checkbox"/>
Child Support	<input type="checkbox"/>	<input type="checkbox"/>
Other (explain)	<input type="checkbox"/> _____	<input type="checkbox"/> _____

Emergency Contacts

(Other than parents)

#1
Name: _____ Relationship _____
Address: _____
City/State/Zip _____
Phone: H/C/M/W: () _____
Emergency Contact? Yes No
Release To? Yes No

#2
Name: _____ Relationship _____
Address: _____
City/State/Zip _____
Phone: H/C/M/W: () _____
Emergency Contact? Yes No
Release To? Yes No

Doctor:

Name _____ Phone: _____
Address: _____ City: _____ State: _____

Dentist:

Name _____ Phone: _____
Address: _____ City: _____ State: _____

Hospital Preference:

Phone: _____
Address: _____ City: _____ State _____

I have carefully reviewed the information in this form and by signing this application, certify to the best of my knowledge and belief that all information in this application is true and correct. I further understand that this is an application for services that are paid with federal funds and that intentionally providing misleading, inaccurate or untruthful information of a material nature could result in dis-enrolling my child from Head Start Early Head Start and is considered fraud and could have serious legal consequences for me.

Parent/Guardian signature: **X** _____ Date: _____

Verifying Staff Member: **X** _____ Date: _____

HACAP Head Start/Early Head Start Listing

Vinton Head Start
202 E 4th Str Vinton

Coral Ridge Head Start
2441 10th Str Coralville

Iowa City Bloomington Head Start
318 E Bloomington Iowa City

Waterfront Head Start
367 Southgate Dr Iowa City

Faith UCC
1609 Deforest Ave Iowa City

Anamosa Head Start
100 Park Ave Anamosa

Inn Circle Head Start/Early Head Start
5560 6th Str SW Cedar Rapids

Olivet Head Start
230 10th Str NW Cedar Rapids

Hayes Head Start
1924 D Str SW Cedar Rapids

Horizons Head Start/ Early Head Start
819 5th Str SE Cedar Rapids

Jane Boyd Head Start
943 14th Ave SE Cedar Rapids

Marion Head Start / Early Head Start
3405 7th Ave Marion

Urban Head Start / Early Head Start
1328 2nd Ave SE Cedar Rapids

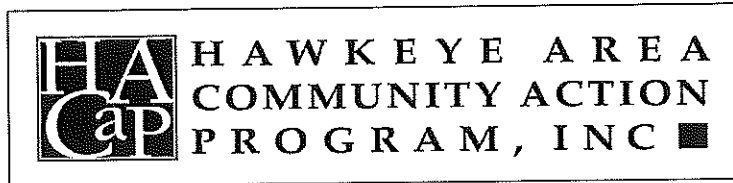
Orchard Hill Head Start
2176 Lexington Blvd Washington

Contracted Head Start Locations:

Partnership Location:

Belle Plaine	Monticello
MISD	Marion
Center Point	College Community
Central City	Williamsburg
Iowa Valley	Marion Independent School

Linn County Child Development Center, Cedar Rapids



**Self-Employment Declaration
HACAP Head Start Full Day Services**

I, _____, declare that I am self-employed and maintain a minimum of 28 hours of work activity each week. The nature of my work is _____

I certify that this information is true. If any part is false, my participation in this agency's programs may be affected. I also understand that the information contained in this form will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent/Guardian Signature

Date

HACAP Staff Signature

Date

Original – Central File
Copy – Child File