



Head Start/Early Head Start Application

Resource Center: 450 Syndicate St. N
Suite 5, St. Paul, MN 55104

Enrollment Hotline: 651-603-5977 Fax: 651-603-5986

Email: hs-apps@caprw.org

Website: www.caprw.org



PARTNERING WITH PEOPLE TO OVERCOME POVERTY
SERVE. EDUCATE. TRANSFORM.

Community Action Head Start/Early Head Start provides free early learning services to qualifying families living in Ramsey County. Families that are low-income, foster children, and families experiencing homelessness (McKinney-Vento) have the highest priority for enrollment, but families with income above the Federal Poverty Guidelines are still welcome to apply. We also welcome children with disabilities and IEPs.

We accept applications year-round. Transportation is offered for Extended Day Head Start
If you currently receive SNAP, MFIP cash or food assistance, or SSI, you are eligible for our program!

Visit our website (www.caprw.org) for more information.

Early Head Start (at home or in the classroom)

For pregnant mothers and parents/caregivers with infants/toddlers under age 3

Options:

- **Home-Based:** weekly home visits and twice monthly family events
- **Center-Based:** year-round child care for 10-11 hours per day for children ages 6 weeks to 3 years
This option requires funding through Childcare Assistance or Think Small Pathway One Scholarship



Head Start (Preschool)

For children who are 3 or 4, or who turn 5 after September 1

Options:

- **Extended Day:** 7.5 hours per day, Monday-Thursday, September-June
- **Full-Year:** 10-11 hours per day, Monday-Friday, Year-Round
This option requires funding through Childcare Assistance or Think Small Pathway One Scholarship.



Please fill out this application clearly, sign the application, and turn it in.

- Email a clear photo or scan of the application to hs-apps@caprw.org
- Drop it off at the Community Action Building at 450 Syndicate St N, St. Paul, MN 55104
- Mail it to the Community Action Building at 450 Syndicate St. N, Ste. 5, St. Paul, MN 55104
- Drop it off in person at any of our Centers (see our website for a list!)
- Fax it to 651-603-5986

Items to turn in for a COMPLETE application:

- Proof of child's birthday (medical records, passport, birth certificate, I-94, etc.)
- Child's Immunization record
- Proof of family eligibility or income: taxes, paystubs, W2, SNAP proof, TANF proof, SSI proof, foster care letter, McKinney-Vento/Homeless proof e.g. shelter address, letter describing living situation

****Please also turn in Physical and Dental forms as soon as possible (blank forms can be found on caprw.org)

Xav tau kev pab hu |
Hadii aad rabto caawimaad wac | Ayuda para solicitar

Notice of Privacy Practices (please keep this page for your records)

Community Action Partnership of Ramsey and Washington Counties – Head Start Program

Effective February 1, 2020

This notice tells you how private information about you may be used and disclosed and how you can get this information. Please review it carefully. When you sign this application, you are telling us that we can share the information on this application with the people and organizations listed below.

Why do we ask for this information?

In order to determine whether and how we can help you, we collect information:

- To tell you apart from other people with the same or similar name
- To decide what you are eligible for
- To help you get medical, mental health, financial or social services and decide if you can pay for some services
- To decide if you or your family need protective services
- To decide about out-of-home care and in-home care for you or your children
- To investigate the accuracy of the information in your application

After we have begun to provide services or support to you, we may collect additional information:

- To make reports, do research, do audits, and evaluate our programs
- To investigate reports of people who may lie about the help they need
- To collect money from other agencies, like insurance companies, if they should pay for your care
- To collect money from the state or federal government for help we give you.
- When your or your family's circumstances change, and you are required to report the change.

Do you have to answer the questions we ask?

You do not have to give us your personal information. Without the information, we may not be able to help you. If you give us wrong information on purpose, you can be investigated and charged with fraud.

With whom may we share information?

We will only share information about you as needed and as allowed or required by law. We may share your information with the following agencies or persons who need the information to do their jobs:

- Employees or volunteers with other state, county, local, federal, collaborative, nonprofit and private agencies
- Researchers, auditors, investigators, and others who do quality of care reviews and studies or commence prosecutions or legal actions related to managing the human services programs.
- Court officials, county attorney, attorney general, other law enforcement officials, child support officials, and child protection and fraud investigators
- Human services offices, including child support enforcement offices
- Governmental agencies in other states administering public benefits programs
- Health care providers, including mental health agencies and drug and alcohol treatment facilities
- Health care insurers, health care agencies, managed care organizations and others who pay for your care
- Guardians, conservators or persons with power of attorney
- Coroners and medical investigators if you die and they investigate your death
- Anyone else to whom the law says we must or can give the information.

What are your rights regarding the information we have about you?

- You and people you have given permission to, may see and copy private information we have about you.
- You may question if the information we have about you is correct. Send your concerns in writing. Tell us why the information is wrong or not complete. Send your own explanation of the information you do not agree with. We will attach your explanation any time information is shared with another agency.
- You have the right to ask us in writing to share information with you in a certain way or in a certain place. For example, you may ask us to send health information to your work address instead of your home address. If we find that your request is reasonable, we will grant it.
- You have the right to ask us to limit or restrict the way that we use or disclose your information, but we are not required to agree to this request.
- If you do not understand the information, ask your family worker to explain it to you. You can ask for another copy of this notice.

What are our responsibilities?

- We must protect the privacy of your private information according to the terms of this notice.
- We may not use your information for reasons other than the reasons listed on this form or share your information with individuals and agencies other than those listed on this form unless you tell us in writing that we can.
- We must follow the terms of this notice, but we may change our privacy policy because privacy laws change.

What privacy rights do children have?

If you are under 18, when parental consent for medical treatment is not required, information will not be shown to parents unless the health care provider believes not sharing the information would risk your health. Parents may see other information about you and let others see this information, unless you have asked that this information not be shared with your parents. You must ask for this in writing and say what information you do not want to share and why. If the agency agrees that sharing the information is not in your best interest, the information will not be shared with your parents. If the agency does not agree, the information may be shared with your parents if they ask for it.

What if you believe your privacy rights have been violated?

If you think that Community Action Partnership of Ramsey and Washington Counties has violated your privacy rights, you may send a written complaint to the address below:

Community Action Partnership of Ramsey and Washington Counties
Attn: Senior Director – Head Start
450 N Syndicate St.
Suite 5
St. Paul, MN 55104

“This information is available in alternative formats to individuals with disabilities upon request. Contact us at 651-603-5977. Community Action Head Start is an Equal Opportunity Employer.”

SECTION ONE: FAMILY INFORMATION

APPLICANT (Child or Pregnant Person) (if there are more than 2 applicants, use the Other Family Members section)

First Name	Last Name	Date of Birth	Sex	Race	Ethnicity
		/ /	M F		Hispanic Non Hispanic
		/ /	M F		Hispanic Non Hispanic

PARENTS/PRIMARY GUARDIANS

Parent/Guardian #1 First Name	Last Name	Relationship to Applicant	Date of Birth	Sex	Race	Ethnicity
			/ /	M F		Hispanic Non Hispanic

Phone Number: _____ **Ok to text?** **Email:** _____

Parent/Guardian #2 First Name	Last Name	Relationship to Applicant	Date of Birth	Sex	Race	Ethnicity
			/ /	M F		Hispanic Non Hispanic

Phone Number: _____ **Ok to text?** **Email:** _____

OTHER FAMILY MEMBERS (include all people living in your home, attach another page if necessary)

First Name	Last Name	Relationship to Applicant	Date of Birth	Sex	Race	Ethnicity
			/ /	M F		Hispanic Non Hispanic
			/ /	M F		Hispanic Non Hispanic
			/ /	M F		Hispanic Non Hispanic
			/ /	M F		Hispanic Non Hispanic

ADDRESS AND LIVING SITUATION

Home Address (include apt/unit number)	Zip	City, State
Mailing Address (if different than Home Address)		

Current Living Situation: <input type="checkbox"/> Own/Rent/Share by choice <input type="checkbox"/> Sharing due to loss of housing/hardship <input type="checkbox"/> Shelter/Transitional <input type="checkbox"/> Hotel/Camp/Car/etc. <input type="checkbox"/> Home in foreclosure/getting evicted <input type="checkbox"/> Other: _____	Homeless in last 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Language(s) spoken at home: _____	Do you need an Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Applicant(s) Name and Date of Birth:**SECTION 2: EMPLOYMENT AND INCOME (check all that apply – please turn in proof of family eligibility or income)**

Parent/Guardian 1 Employment: Employed | Stay at Home
 Retired/Disabled | Student | Collecting Unemployment

Parent/Guardian 2 Employment: Employed | Stay at Home
 Retired/Disabled | Student | Collecting Unemployment

Other Sources of Income: Supplemental Security Income SSI (anyone in family) | MFIP/DWP cash assistance
 Child Support | School grants/Scholarships | SNAP (food stamps)

No Income: Parent/Guardian(s) declares **none of the above** income in the last **12 months**. Explain how your family provided for basic living necessities during the time when you had no income:

Child Custody: Both Parents, same home | Both Parents, separate homes | Single Parent
 Court-ordered Guardianship/Foster Care/Kinship Care | Other (e.g. Delegation of Parental Authority):

SECTION 3: SPECIAL NEEDS, DISABILITY, AND HEALTH CONCERNS

Do you know or suspect that your child needs support in any of the following areas? (If YES, please check)

Special needs, disabilities, and health concerns do not disqualify children from participating.

<input type="checkbox"/> Child has food allergies	<input type="checkbox"/> Behavioral Concerns	<input type="checkbox"/> Child needs medication at school
<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Vision/Hearing Impairment	<input type="checkbox"/> Speech Concerns
<input type="checkbox"/> Autism	<input type="checkbox"/> Mental Health Diagnosis	<input type="checkbox"/> Other:

Does your child currently have an IEP/IFSP? Yes (please attach copy) | No | In evaluation process/testing
I give permission to Community Action HS/EHS to request and share information about my child with the School District for my home zip code.

Child(ren) name: _____ Date of Birth: _____

Parent/Guardian Signature: _____ Date: _____ Home Zip code: _____

SECTION 4: PREFERRED PROGRAM OPTION

EXTENDED DAY (8hrs/day Mon-Thurs) | **HOME-BASED** (0-3 years old home visiting)
 FULL DAY (10hrs/day Mon-Fri, requires Childcare Assistance funding or the Think Small Pathway One scholarship)

SECTION 5: CONSENTS AND AUTHORIZATIONS

Initials	I understand that Community Action Head Start may share the data on or included with this application with other human service programs operated by Community Action Partnership of Ramsey and Washington Counties.
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Initials	To the best of my knowledge, the information I have provided is accurate and true. I acknowledge that I have received a copy of the Notice of Privacy Practices. In accordance with the Minnesota Government Data Practices and the federal Health Insurance Portability and Accountability Act (HIPAA), I have been informed and understand my rights.
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Signature: _____ Date: _____

Alternate contacts if we can't reach you:

First & Last Name: _____ Relationship: _____ Phone Number: _____

First & Last Name: _____ Relationship: _____ Phone Number: _____

How did you hear about Head Start/Early Head Start?

Doctor/Social Worker Ramsey County Service Worker WIC Family/Friend HS Staff/Event
 Another child in HS Walk-in (CAPRW) Other: _____

SECTION 6: NO INCOME/HOMELESSNESS VERIFICATION (STAFF USE ONLY)

I verify that this family: Is homeless under McKinney-Vento Had no income for the past 12 months/calendar year

Staff Name:	Notes/Source:
Signature:	Date: