

Head Start/Early Head Start Application

Main Office: 450 N Syndicate St., Suite 5, St. Paul, MN 55104

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

Email: hs-apps@caprw.org

Website: www.caprw.org

Facebook/Twitter/Instagram: @caprwheadstart



Community Action Head Start/Early Head Start provides free early learning services to eligible families. Income qualifying children and families with the greatest need have the highest priority for enrollment, and families with income above the Federal guidelines are still able to enroll. We accept applications year-round. Services are available to children with disabilities and homeless children.

Early Head Start

- For pregnant mothers and parents/caregivers with infants/toddlers under age 3
- Weekly home visits (not classroom) and twice monthly family events.

Head Start

- For children who are 3 or 4, or who turn 5 after September 1
- **Part day** (3.5 hours/day, Mon-Thurs) September-May some transportation available
- **Full day** (7.5 hours/day, Mon-Thurs) September-June some transportation available
- **Year-Round** (center is open 7am-6pm, Monday-Friday year round) Families must have child care funding to be eligible. Transportation is NOT available.

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caawimaad wac

Ayuda para solicitar

651-603-5977

Please PRINT CLEARLY and fill out the front and back page of the application. Sign and date then turn in using one of the following options:

- Mail or drop off at the Main Office or Center near you (see below) 8:30am—4:30pm
- Email or send pictures of both pages to hs-apps@caprw.org
- Fax to **651-603-5986**
- After hours at Main Office available 2nd Wednesday of every month until 7pm

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 or paystubs)

*Foster Care, receiving MFIP/SSI/DWP, or experiencing homelessness—documentation is required.

**We consider gross income from all jobs the 12 months before this application or last year's income (Jan-Dec), whichever is more accurate to your current situation.

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

Our Centers and Locations:

- Battle Creek - 2181 Suburban Ave. St Paul, MN 55119
- McDonough - 1544 Timberlake Rd. St Paul, MN 55117
- Midway - 775 Lexington Pkwy N St Paul, MN 55104
- Mounds View - 2101 14th St NW New Brighton, MN 55112
- Mt. Airy - 91 Arch St E St Paul, MN 55130
- North St Paul - 2499 Helen St N North St Paul, MN 55109
- Roosevelt - 1575 Ames Ave St Paul, MN 55106
- Ruth Benner - 586 Fuller Ave St Paul, MN 55103
- Skyline Towers - 1247 St. Anthony Ave St Paul, MN 55104
- University/Main Office (Community Action) - 450 Syndicate St N St Paul, MN 55104 (next to Midway Target)
- West Side - 271 Belvidere St E St Paul, MN 55107



Notice of Privacy Practices (please keep for your records)

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

Effective February 1, 2020

This notice tells how private information about you may be used and disclosed and how you can get this information. Please review it carefully.

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 1: FAMILY INFORMATION								
Home Address <small>(include apartment/unit number)</small>			Zip	City, State				
Mailing Address <input type="checkbox"/> Home <input type="checkbox"/> Other:								
Pick-up/Drop-off Address <small>(if different from home address)</small>			Zip	City, State				
			Can you self-transport? <input type="checkbox"/> Yes <input type="checkbox"/> No					
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/Motel/Camp/Car/etc. <input type="checkbox"/> Home in foreclosure/getting evicted (date: _____) <input type="checkbox"/> Other:					Homeless in last 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No			
STAFF USE ONLY: Homeless verification source: _____ Staff initials: _____ Eligible as homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Parent/Guardian 1 Phone: <input type="checkbox"/> Please do not text		<input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Home		Parent/Guardian 2 Phone: <input type="checkbox"/> Please do not text		<input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Home		
Parent/Guardian 1 Email:			Parent/Guardian 2 Email:					
Emergency contact 1: Address:		Relationship:		Phone:				
Emergency contact 2: Address:		Relationship:		Phone:				
Do you speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No How Well? <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		Language spoken at home:			Do you need an Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Parent/Guardian 1 Highest Education <input type="checkbox"/> Grade 12 or less <input type="checkbox"/> HS Diploma/GED <input type="checkbox"/> Some college <input type="checkbox"/> Associates <input type="checkbox"/> BS/BA <input type="checkbox"/> MS			Parent/Guardian 2 Highest Education <input type="checkbox"/> Grade 12 or less <input type="checkbox"/> HS Diploma/GED <input type="checkbox"/> Some college <input type="checkbox"/> Associates <input type="checkbox"/> BS/BA <input type="checkbox"/> MS					
Child Custody: <input type="checkbox"/> Both Parents <input type="checkbox"/> Parent 1 ONLY <input type="checkbox"/> Parent-appointed Guardianship/Kinship Care <input type="checkbox"/> Court-ordered Guardianship/Foster/DHS <input type="checkbox"/> Other (PSOP, etc.):			Is your family expecting a baby? <input type="checkbox"/> Yes <input type="checkbox"/> No Due date: _____ Apply for EHS? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Include all people living in your home. Attach another page if you need more room. Use codes for Race: NA/AN=American Indian/Alaska Native A=Asian B=Black/African American NH/PI=Native Hawaiian or Other Pacific Islander W=White M=Multi-racial								
Applying for:	Applicant's First Name	Applicant's Last Name	Date of Birth	Sex	Race	Ethnicity		
EHS or HS: Part Full			/ /	M F		Hispanic Non Hispanic		
EHS or HS: Part Full			/ /	M F		Hispanic Non Hispanic		
EHS or HS: Part Full			/ /	M F		Hispanic Non Hispanic		
Applying for: (circle 1)	Relationship to Applicant	First Name	Last Name	Date of Birth	Sex	Race	Ethnicity	Living in Home?
EHS (if pregnant)	Parent/Guardian 1 (from above)			/ /	M F		Hispanic Non Hispanic	Yes No
EHS (if pregnant)	Parent/Guardian 2 (from above)			/ /	M F		Hispanic Non Hispanic	Yes No
				/ /	M F		Hispanic Non Hispanic	Yes No
				/ /	M F		Hispanic Non Hispanic	Yes No
				/ /	M F		Hispanic Non Hispanic	Yes No
				/ /	M F		Hispanic Non Hispanic	Yes No

Applicant(s) Name and Date of Birth: _____

SECTION 2: EMPLOYMENT AND INCOME (Proof of income is required for eligibility (paystubs, last year's taxes, W2, etc.))

Parent/Guardian 1 Employment: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Retired/Disabled <input type="checkbox"/> Training/School <input type="checkbox"/> Military <input type="checkbox"/> Stay at Home <input type="checkbox"/> Self-employed <input type="checkbox"/> Unemployment (last day worked: _____)	Parent/Guardian 2 Employment: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Retired/Disabled <input type="checkbox"/> Training/School <input type="checkbox"/> Military <input type="checkbox"/> Stay at Home <input type="checkbox"/> Self-employed <input type="checkbox"/> Unemployment (last day worked: _____)
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Other Sources of Income: SSI | MFIP/DWP cash | Child Support | School grants/Scholarships

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:

SECTION 3: SPECIAL NEEDS, DISABILITY AND HEALTH CONCERNS

Do you or someone else suspect 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 allergies	<input type="checkbox"/> Child has health condition	<input type="checkbox"/> Child takes medication	<input type="checkbox"/> Child has dietary concerns
<input type="checkbox"/> Developmental Delay(s)	<input type="checkbox"/> Behavioral Concerns	<input type="checkbox"/> Attention Deficit Disorder	<input type="checkbox"/> Autism
<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Mental Health Diagnosis	<input type="checkbox"/> Vision Impairment	<input type="checkbox"/> Orthopedic Impairment
<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Speech Impairment	<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.

Child(ren) name and D.O.B. with IFSP/IEP: _____

Parent/Guardian Signature: _____ Date: _____ School District: _____

<input type="checkbox"/> Child applicant born prematurely	<input type="checkbox"/> Death of child's immediate family member	<input type="checkbox"/> Household member with: <input type="checkbox"/> special needs <input type="checkbox"/> mental health concerns <input type="checkbox"/> health condition(s) <input type="checkbox"/> history of substance abuse
<input type="checkbox"/> No Health Insurance for child	<input type="checkbox"/> Incarcerated parent (previously or currently)	
<input type="checkbox"/> No Health Insurance for family	<input type="checkbox"/> Domestic abuse or family violence	

SECTION 4: 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.
Initials	I understand that Community Action Head Start may share the data on or included with this application with the local school district and public health agency.
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.

Signature(s): _____ Date: _____

How did you hear about Head Start/Early Head Start?	Where did you get this application?
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SECTION 5: ENROLLMENT NOTES (FOR STAFF USE ONLY)

Interviewed by:	Interview Date:	Interview Type:
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Notes: (describe efforts to verify no income and homelessness)