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

Community Action Partnership of Ramsey & Washington Counties
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.

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 and for current Federal Poverty Guidelines.

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
  Limited transportation is offered for Extended Day Head Start programming.
- **Full-Year:** 10-11 hours per day, Monday-Friday, Year-Round
  There is no transportation available for Full-Year programming.

Parent Aware Highest Possible Rating

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— check out our locations at caprw.org/head-start
- ☐ 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 solicitor

Application help in other languages, please call the Enrollment Hotline: 651-603-5977

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."

Please turn in this application to Head Start (450 Syndicate St. N St Paul, MN 55104; FAX 651-603-5986; or email hs-apps@caprw.org)

SECTION 1: PREFERRED PROGRAM OPTION

☐ **EXTENDED DAY** (7.5 hrs/day Mon-Thurs, limited transportation)
☐ **HOME-BASED** (0-3 years old home visiting)
☐ **SPPS PreK PARTNER** (6.5 hrs/day, Mon-Fri)
☐ **HEAD START PARTNERS** (hours/days may vary)
☐ **FULL DAY** (10hrs/day Mon-Fri, requires CCAP funding or the Think Small Pathway One scholarship, no transportation)

SECTION 2: 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

PARENT/GUARDIAN #1:

Is parent pregnant?
☐ Yes ☐ No If yes, due date:_____

Is parent interested in EHS Services?
☐ Yes ☐ No

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

Parent/Guardian 1 Education:
☐ Grade 12 or less | ☐ High School Diploma/GED or equivalent
☐ Some College—no degree yet | ☐ Associates
☐ Bachelor's | ☐ Master's or higher

PARENT/GUARDIAN #2:

Is parent pregnant?
☐ Yes ☐ No If yes, due date:_____

Is parent interested in EHS Services?
☐ Yes ☐ No

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:

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

Parent/Guardian 2 Education:
☐ Grade 12 or less | ☐ High School Diploma/GED or equivalent
☐ Some College—no degree yet | ☐ Associates
☐ Bachelor's | ☐ Master's or higher

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): _____

Applicant(s) Name and Date of Birth:_____

SECTION 2 (cont.): FAMILY INFORMATION

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: _____

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

Language(s) spoken at home:

Primary: _____ **Secondary:** _____

Do you need an Interpreter? ☐Yes | ☐No

SECTION 3: ADDRESS AND LIVING SITUATION

Home Address (include apt/unit number)	**Zip**	**City, State**

Mailing Address (if different than Home Address)

Current Living Situation: ☐Own/Rent/Share by choice | ☐Sharing due to loss of housing/hardship ☐Shelter/Transitional | ☐Hotel/Camp/Car/etc. | ☐Home in foreclosure/getting evicted

☐Other:

Homeless in last 2 years? ☐Yes | ☐No

SECTION 4: PARTICIPANT INFORMATION

Transportation (available for Extended Day option only):

☐ Needs Bus

☐ Self-transport

☐ Can Self-Transport, but bus preferred

Funding Source (required for Full Day option only):

☐ I have no funding, but want to apply

☐ I have Pathway 1 funding

☐ I have Child Care Assistance (CCAP)

SECTION 5: CONSENTS AND AUTHORIZATIONS

Initials	
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	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: _____ Date: _____

Applicant(s) Name and Date of Birth:_____

SECTION 6: DISABILITIES, ACCOMODATIONS & ROI

Do you know or suspect that your child needs support in any of the following areas? (If YES, please check)
Disabilities do not disqualify children from participating.

☐ Behavioral Concerns	☐ Mental Health Diagnosis	☐ Autism
☐ Developmental Delay	☐ Vision/Hearing Impairment	☐ Speech Concerns

☐ Other Concerns (Please List):

_____

_____

IEP/IFSP RELEASE OF INFORMATION (ROI):
Please complete what you can. This is not a required field.

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 zipcode.

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

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

SECTION 7: HEALTH CONCERNS, ALLERGIES & ROI

Do you know or suspect that your child needs support in any of the following areas? (If YES, please check)
Health concerns do not disqualify children from participating.

☐ Child has food allergies	☐ Asthma/Breathing Difficulties	☐ Seizures/Convulsions	☐ Diabetes

☐ Other Allergies (Please List):	☐ Child needs medication at school (Please List):
_____	_____
_____	_____
_____	_____

HEALTH RELEASE OF INFORMATION (ROI):
Please complete what you can.

By checking the boxes below and signing this form, you authorize Community Action Early Head Start/Head Start staff to contact the Medical Providers listed below to exchange (request, receive and release) information about you/your child; and release information about you/your child for the purposes of gathering required medical documentation for enrollment purposes.

Name of Doctor/Physician: _____ Phone:_____

Name of Dentist: _____ Phone:_____

Health Insurance (if available): _____ Medical ID (if available):_____

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

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

Applicant(s) Name and Date of Birth:_____

SECTION 8: EMERGENCY CONTACTS

Emergency Contacts #1:

First Name: _____ Last Name: _____ Relationship: _____

Home Phone Number: _____ Work Phone (optional): _____

Primary Language: _____Interpreter Needed? ☐ Yes ☐ No

Address: _____ Zip Code: _____

City: _____ State: _____

Emergency Contacts #2:

First Name: _____ Last Name: _____ Relationship: _____

Home Phone Number: _____ Work Phone (optional): _____

Primary Language: _____Interpreter Needed? ☐ Yes ☐ No

Address: _____ Zip Code: _____

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:**_____

Thank you for completing the Head Start application!

Please submit *one* the following with your application:	**Please submit *one* the following with your application:**
☐ Income documents (recent paystub, W2, taxes)	☐ Immunization or medical records
☐ Picture of active SNAP Card, MAXIS, TANF, or SSI statements	☐ I-94 or any other proof of birthday

Email it 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 | Fax it to 651-603-5986 | Drop it off in person at any of our Centers— check out our locations at caprw.org/head-start

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

Notes/Source:

_____

_____

_____

_____

_____

Staff Name:

Signature:	Date: