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 no cost early learning services to eligible families living in Ramsey County. Income qualifying children and families with the greatest need have the highest priority for enrollment, and families with income above the Federal Poverty guidelines are still able to enroll. We accept applications year-round. Services are available to children with disabilities and homeless children.

Visit our website (www.caprw.org) for our full list of centers!

Early Head Start (Home-based and Center-based)

- For **pregnant mothers** and parents/caregivers with infants/toddlers under age 3
- Weekly **home visits** (not classroom) and twice monthly family events.
- **Full-Year Center-based Infant** and **Toddler** (6 weeks-3 years old)
  Center is open 10 or 11 hours/day, Mon-Fri—requires CCAP/Pathway 1. Transportation is NOT available.

Head Start (Center-based)

- 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
- **Extended day** (7.5 hours/day, Mon-Thurs) September-June some transportation available
- **Full-Year** (Center is open 10 or 11 hours/day, Monday-Friday year round)
  Requires CCAP/Pathway 1. Transportation is NOT available.

Parent Aware Highest Possible Rating

Please PRINT CLEARLY, fill out the front and back, and then turn in using one of the following options:

- Mail/drop off at the Community Action Resource Center or Center near you (see below) 8:30am—4:30pm
  ⇒ After hours at the Resource Center available 2nd Wednesday of every month until 7pm
- Email pictures or scans of both application pages and supporting documents to **hs-apps@caprw.org**
- Fax 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**

**Foster Care, receiving MFIP/SSI/DWP, or experiencing homelessness—documentation is required.*
***We consider gross income (before taxes) from all jobs worked in the last 12 months. Please turn in your most recent pay stub for each job.*
***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 | မှုမှ်ပှၤကညီကိးဘဉ်

Hadii aad rabto caawimaad wac | Ayuda para solicitar

651-603-5977

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

Revised – 05/2021

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."

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: FAMILY INFORMATION

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

Mailing Address (if different than Home)

Pick-up/Drop-off Address (if different from home address) **Can you self-transport?** ☐Yes |☐No	**Zip**	**City, State**

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

Homeless in last 2 years? ☐Yes | ☐No

STAFF USE ONLY: Homeless verification source: _____ Staff initials: _____ Eligible as homeless? ☐Yes | ☐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**	**M.I.**	**Applicant's Last Name**	**Date of Birth**	**Sex**	**Race**	**Ethnicity**
EHS: Home or Center HS: Part or Full				/ /	M F		Hispanic Non Hispanic
EHS: Home or Center HS: Part or Full				/ /	M F		Hispanic Non Hispanic
EHS: Home or Center HS: Part or Full				/ /	M F		Hispanic Non Hispanic

Relationship to Applicant(s)	**First Name** (other family members living in home)	**M.I.**	**Last Name** (other family members living in home)	**Date of Birth**	**Sex**	**Race**	**Ethnicity**
Parent/Guardian 1				/ /	M F		Hispanic Non Hispanic
Parent/Guardian 2				/ /	M F		Hispanic Non Hispanic
				/ /	M F		Hispanic Non Hispanic
				/ /	M F		Hispanic Non Hispanic
				/ /	M F		Hispanic Non Hispanic
				/ /	M F		Hispanic Non Hispanic

Child Custody: ☐Both Parents | ☐Parent 1 ONLY ☐Parent-appointed Guardianship | ☐Court-ordered Guardianship/Foster/ DHS/Kinship | ☐Other (PSOP, etc.):	**Is your family expecting a baby?** ☐Yes |☐No Due date: _____ **Apply for EHS?** ☐Yes | ☐No
Parent/Guardian 1 Phone: ☐Please do not text	**Parent/Guardian 2 Phone:** ☐Please do not text
Parent/Guardian 1 Email:	**Parent/Guardian 2 Email:**

Emergency contact 1 Name: **Relationship:** **Phone:**
Address:

Emergency contact 2 Name: **Relationship:** **Phone:**
Address:

Language(s) spoken at home:	**Do you need an Interpreter?** ☐Yes | ☐No

Parent/Guardian 1 Highest Education ☐Grade 12 or less ☐HS Diploma/GED | ☐Some college | ☐Associates | ☐BS/BA | ☐MS	**Parent/Guardian 2 Highest Education** ☐Grade 12 or less ☐HS Diploma/GED | ☐Some college | ☐Associates | ☐BS/BA | ☐MS

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

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:☐Full Time |☐Part Time ☐Seasonal | ☐Retired/Disabled | ☐Training/School | ☐Military ☐Stay at Home | ☐Self-employed | ☐Unemployment (last day worked: _____)	**Parent/Guardian 2 Employment:**☐Full Time |☐Part Time ☐Seasonal | ☐Retired/Disabled | ☐Training/School | ☐Military ☐Stay at Home | ☐Self-employed | ☐Unemployment (last day worked: _____)

Other Sources of Income: ☐SSI (anyone in family) | ☐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.

☐ Child has allergies	☐ Child has health condition	☐ Child takes medication	☐ Child has dietary concerns
☐ Developmental Delay(s)	☐ Behavioral Concerns	☐ Attention Deficit Disorder	☐ Autism
☐ Down Syndrome	☐ Mental Health Diagnosis	☐ Vision Impairment	☐ Orthopedic Impairment
☐ Hearing Impairment	☐ Speech Impairment	☐ 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: _____

☐ Child applicant born prematurely	☐ Death of child's immediate family member	☐ Household member with: ☐ special needs ☐ mental health concerns ☐ health condition(s) ☐ history of substance abuse
☐ No Health Insurance for child	☐ Incarcerated parent (previously or currently)	
☐ No Health Insurance for family	☐ 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: _____ Date: _____

How did you hear about Head Start/Early Head Start?	**Where did you get this application?**

SECTION 5: ENROLLMENT NOTES (FOR STAFF USE ONLY)

Interviewed by:	Interview Date:	Interview Type:

Notes: (describe efforts to verify no income and homelessness)