Kickapoo Head Start
211 S. West Street, PO Box 127
Powhattan, KS 66527
Phone: (785) 474-3231
Fax: (785) 474-3249

Dear Head Start/Early Head Start Applicant,

Please complete the attached enrollment application and provide copies of the following list of documents. Only complete applications can be reviewed and processed. A complete application includes the following:

- ☐ CDIB Card for applicant (if applicable)
- ☐ CDIB Card for parent (if applicable)
- ☐ Current Proof of Income (pay stub or tax return)
- ☐ Current Insurance Card (or denial letter)
- ☐ Social Security Card for applicant
- ☐ Current Immunization Record
- ☐ Birth Certificate
- ☐ Recent Physical Exam (required every year) or proof of scheduled appointment
- ☐ Recent Hemoglobin Count (required every year)
- ☐ Recent Blood Lead Screening Questionnaire (required every year)
- ☐ Blood Lead Level Test (@ 12 month /24 month /questionnaire shows positive response)
- ☐ Recent Dental Exam (every year) or proof of scheduled appointment

Providing the above documents will allow staff to review the application and determine the applicant(s) eligibility for the Head Start/Early Head Start Program. A Head Start/Early Head Staff member will notify individuals with incomplete applications. Incomplete applicants will be placed on the waiting list and cannot be reviewed for enrollment until it has been completed.

If you need assistance filling out the application or have any questions, please feel free to contact Kickapoo Head Start/Early Head Start. We can be reached at (785) 474-3231, Monday through Friday 8:00 a.m. to 4:00 p.m.

Sincerely,

Kickapoo Head Start/Early Head Start Staff

KICKAPOO HEAD START / EARLY HEAD START ENROLLMENT APPLICATION

SECTION I: PRIMARY ADULT

LAST NAME:	FIRST NAME:	MIDDLE NAME:	PREFERRED NAME:
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	GENDER: MALE FEMALE	ETHNICITY: HISPANIC NON-HISPANIC

RACE:

KS KICKAPOO MEMBER   KS KICKAPOO DESCENDENT   MEMBER OF ANOTHER TRIBE   NATIVE AMERICAN DESCENDENT   ASIAN   BLACK/ AFRICAN AMERICAN   WHITE   HAWAIIAN/PACIFIC ISLANDER

MULTI-RACE (TWO OR MORE)   HISPANIC   UNSPECIFIED   CDIB #: ______________________________

EMPLOYMENT / JOB TRAINING AND/OR SCHOOL

EMPLOYER: __________________________   JOB TRAINING LOCATION / SCHOOL: __________________________

FULL TIME   PART TIME   FULL TIME   PART TIME

SCHEDULE: Sunday: ______________   SCHEDULE: Sunday: ______________
Monday: ______________   Monday: ______________
Tuesday: ______________   Tuesday: ______________
Wednesday: ______________   Wednesday: ______________
Thursday: ______________   Thursday: ______________
Friday: ______________   Friday: ______________
Saturday: ______________   Saturday: ______________

EDUCATION: HIGHEST GRADE COMPLETED:

0 – 8TH GRADE   9TH – 12TH (NON GRAD)   GED

HIGH SCHOOL GRADUATE   SOME COLLEGE

VOCATIONAL SCHOOL   ASSOCIATE DEGREE

BACHELORS DEGREE   MASTER'S DEGREE

CURRENTLY PREGNANT:	TEEN PARENT:	MARITAL STATUS:	PRIMARY LANGUAGE SPOKEN:	DISABILITY:
YES NO NOT SURE	YES NO	SINGLE MARRIED SEPARATED DIVORCED WIDOWED NEVER MARRIED	ENGLISH NATIVE AMERICAN LANGUAGE: ______________ SPANISH AMERICAN SIGN LANGUAGE OTHER ______________	YES NO

SECTION II: SECONDARY ADULT

LAST NAME:	FIRST NAME:	MIDDLE NAME:	PREFERRED NAME:
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	GENDER: MALE FEMALE	ETHNICITY: HISPANIC NON-HISPANIC

RACE:

KS KICKAPOO MEMBER   KS KICKAPOO DESCENDENT   MEMBER OF ANOTHER TRIBE   NATIVE AMERICAN DESCENDENT   ASIAN   BLACK/ AFRICAN AMERICAN   WHITE   HAWAIIAN/PACIFIC ISLANDER

MULTI-RACE (TWO OR MORE)   HISPANIC   UNSPECIFIED   CDIB #: ______________________________

EMPLOYMENT / JOB TRAINING AND/OR SCHOOL

EMPLOYER: __________________________   JOB TRAINING LOCATION / SCHOOL: __________________________

FULL TIME   PART TIME   FULL TIME   PART TIME

SCHEDULE: Sunday: ______________   SCHEDULE: Sunday: ______________
Monday: ______________   Monday: ______________
Tuesday: ______________   Tuesday: ______________
Wednesday: ______________   Wednesday: ______________
Thursday: ______________   Thursday: ______________
Friday: ______________   Friday: ______________
Saturday: ______________   Saturday: ______________

EDUCATION: HIGHEST GRADE COMPLETED:

0 – 8TH GRADE   9TH – 12TH (NON GRAD)   GED

HIGH SCHOOL GRADUATE   SOME COLLEGE

VOCATIONAL SCHOOL   ASSOCIATE DEGREE

BACHELORS DEGREE   MASTER'S DEGREE

CURRENTLY PREGNANT:	TEEN PARENT:	MARITAL STATUS:	PRIMARY LANGUAGE SPOKEN:	DISABILITY:
YES NO NOT SURE	YES NO	SINGLE MARRIED SEPARATED DIVORCED WIDOWED NEVER MARRIED	ENGLISH NATIVE AMERICAN LANGUAGE: ______________ SPANISH AMERICAN SIGN LANGUAGE OTHER ______________	YES NO

SECTION III: FAMILY TYPE

SINGLE FEMALE   SINGLE MALE   TWO PARENTS   FOSTER PARENT   LEGAL GUARDIAN

SECTION IV: HOUSING SITUATION

OWN   RENT   BUYING   HOMELESS   OTHER

*HOMELESS: THE OFFICE OF HEAD START GIVES PRIORITY TO FAMILIES THAT ARE CONSIDERED HOMELESS. THE TERM "HOMELESS CHILDREN AND YOUTH" MEANS INDIVIDUALS WHO LACK A FIXED, REGULAR, AND ADEQUATE NIGHTTIME RESIDENCE AND INCLUDES:

- CHILDREN AND YOUTHS WHO ARE SHARING THE HOUSING OF OTHER PERSONS DUE TO LOSS OF HOUSING, ECONOMIC HARDSHIP, OR A SIMILAR REASON; ARE LIVING IN MOTELS, HOTELS, TRAILER PARKS, OR CAMPING GROUNDS DUE TO THE LACK OF ALTERNATIVE ACCOMMODATIONS; ARE LIVING IN EMERGENCY OR TRANSITIONAL SHELTERS; ARE ABANDONED IN HOSPITALS; ARE AWAITING FOSTER CARE PLACEMENT; CHILDREN AND YOUTHS WHO HAVE A PRIMARY NIGHTTIME RESIDENCE THAT IS A PUBLIC OR PRIVATE PLACE NOT DESIGNED FOR OR ORDINARILY USED AS A REGULAR SLEEPING ACCOMMODATION FOR HUMAN BEINGS.

SECTION V: ADDRESS AND CONTACT INFORMATION

ADDRESS:	MAILING ADDRESS (IF DIFFERENT)
CITY, STATE, ZIP CODE:	CITY, STATE, ZIP CODE:

HOME PHONE NUMBER:	WORK PHONE: PRIMARY ADULT: ____________________________ SECONDARY ADULT: __________________________	CELL PHONE: PRIMARY ADULT: ____________________________ SECONDARY ADULT: __________________________

SECTION VI: HOUSEHOLD MEMBERS

NAME	RELATIONSHIP TO PRIMARY ADULT	DATE OF BIRTH	SCHOOL/CURRENT GRADE OR OCCUPATION	PROVIDES FINANCIAL SUPPORT (Y / N)

SECTION VII: NON-CUSTODIAL PARENT

NAME: ____

CONTACT NUMBER: ____

STREET ADDRESS: ____

CITY, STATE, AND ZIP: ____

SECTION VIII: SOURCE OF INCOME VERIFICATION FOR PRENATAL MOTHER / MOTHER / FATHER

**List income of parent(s) of child applicant(s) &/or prenatal mother and/or spouse.

FIRST NAME	EMPLOYER(S)	JOB TITLE	WAGE PER HOUR	HOURS PER WEEK	WEEKS PER YEAR	OFFICE USE ONLY DOCUMENT VERIFIED	OFFICE USE ONLY ANNUAL SALARY

**If disability was marked for any household member, state: (Including SS, SSI, SSD, Work Comp, etc.)

FIRST NAME	TYPE OF DISABILITY INCOME	RECEIVED WEEKLY / MONTHLY / QUARTERLY	SPECIFY AMOUNT PER PAYMENT PERIOD	OFFICE USE ONLY DOCUMENT VERIFIED	OFFICE USE ONLY ANNUAL INCOME

**Other household, i.e.: Per capita, Social Security, TANF, Unemployment Benefits, Veteran Benefits, Pension, Int. Div., Alimony, Child Support, Student Aid, Tax Return, Foster Subsidy. If child support, please state amount awarded and amount received.

FIRST NAME	TYPE OF INCOME	RECEIVED WEEKLY/ MONTHLY/ QUARTERLY	SPECIFY AMOUNT PER PAYMENT AWARDED	SPECIFY AMOUNT PER PAYMENT RECEIVED	OFFICE USE ONLY DOCUMENT VERIFIED	OFFICE USE ONLY ANNUAL INCOME

RECEIVES FOOD STAMPS: YES NO RECEIVES WIC: YES NO RECEIVES PUBLIC HOUSING ASSISTANCE: YES NO RECEIVES ENERGY PROGRAM ASSISTANCE: YES NO

I HEREBY STATE THAT I HAVE NO INCOME. EXPLAIN:
____
____
____
____
__________________________.

I HEREBY ATTEST THAT I REVIEWED THE REQUIRED INCOME DOCUMENTATION, COMPARED THE HOUSEHOLD INCOME AND FAMILY SIZE TO THE MOST CURRENT POVERTY INCOME GUIDELINES AND THAT THIS HOUSEHOLD IS ______ INCOME ELIGIBLE TO RECEIVE REQUESTED SERVICES _______ NOT INCOME ELIGIBLE TO RECEIVE REQUESTED SERVICES. I ASSURE THAT THERE ARE COPIES OF THE TYPES OF INCOME ATTACHED WITH THIS APPLICATION. THIS DOES NOT GUARANTEE DELIVERY OF SERVICES.

KICKAPOO HEAD START STAFF MEMBER ____ DATE ____________________

SECTION IX: INCOME ELIGIBILITY GUIDELINES / ELIGIBILITY PRIORITY CRITERIA

KICKAPOO HEAD START / EARLY HEAD START PROGRAMS INCOME ELIGIBILITY GUIDELINES

The following incomes are used to determine income eligibility for the Kickapoo Head Start / Early Head Start programs, according to the Federal Registry (74 FR 4199). Applicants not meeting these guidelines may still be eligible for services. Income is not the only determining factor for eligibility. *See Eligibility Priority Criteria.

Family Size	Weekly Income	Monthly Income	Annual Income
1	$209.88	$902.5	$10,830
2	$282.47	$1214.60	$14,570
3	$354.84	$1525.83	$18,310
4	$427.33	$1837.50	$22,050
5	$499.80	$2149.16	$25,790
6	$572.89	$2460.83	$29,530
7	$644.77	$2772.50	$33,270
8	$717.25	$3084.16	$37,010

**For families with more than 8 members, add $3,740 for each additional person.

**Please circle one number in each category for the program that the applicant is applying for and place total on line:

KICKAPOO **HEAD START** APPLICANT ELIGIBILITY PRIORITY CRITERIA

TRIBAL AFFILIATION

KS KICKAPOO ENROLLED TRIBAL MEMBER	50	_______
KS KICKAPOO TRIBAL DESCENDENT	45	
MEMBER OF ANOTHER TRIBE	40	
NATIVE AMERICAN DESCENDENT	10	
NON-NATIVE AMERICAN	5	

AGE OF CHILD

4 YEAR OLD	20	_______
3 YEAR OLD	10	

SPECIFIC CIRCUMSTANCES

HOMELESS	100	_______
FOSTER CHILD	100	

SPECIAL SERVICES

SPECIAL NEEDS (IEP)	50	_______
SPECIAL CIRCUMSTANCES (SINGLE PARENT, TEENAGE PARENT, RETURNING, HEALTH PROBLEMS, ETC)	10	

RESIDENCE LOCATION

RESERVATION	10	_______
OFF RESERVATION	5	

INCOME STATUS

INCOME ELIGIBLE	50	_______
OVER INCOME	5	

CONTINUITY OF CARE

PAST HEAD START FAMILY	20	_______

**OFFICE USE ONLY APPLICATION NUMBER ___________________ TOTAL POINTS ______________

KICKAPOO **EARLY HEAD START** APPLICANT ELIGIBILITY PRIORITY CRITERIA

TRIBAL AFFILIATION

KS KICKAPOO ENROLLED TRIBAL MEMBER	50	_______
KS KICKAPOO TRIBAL DESCENDENT	45	
MEMBER OF ANOTHER TRIBE	40	
NATIVE AMERICAN DESCENDENT	10	
NON-NATIVE AMERICAN	5	

AGE OF CHILD / APPLICANT

PRENATAL TO 1 YR OLD	30	_______
1 -2 YEAR OLD	20	
2 - 3 YEAR OLD	10	

SPECIFIC CIRCUMSTANCES

HOMELESS	100	_______
FOSTER CHILD	100	

CONTINUITY OF CARE

PAST/CURRENT HEAD START/EARLY HEAD START FAMILY	20	_______

SPECIAL SERVICES

SPECIAL NEEDS (IFSP)	50	_______
SPECIAL CIRCUMSTANCES (RETURNING, HEALTH PROBLEMS, ETC)	10	

RESIDENCE LOCATION

RESERVATION	10	_______
OFF RESERVATION	5	

INCOME STATUS

INCOME ELIGIBLE	50	_______
OVER INCOME	5	

PARENTAL STATUS

TEENAGE EXPECTANT PARENT	50	_______
TEENAGE PARENT	40	
SINGLE PARENT	10	
ATTENDING SCHOOL OR TRAINING	10	
TWO MEMBER HOUSEHOLD	5	

**OFFICE USE ONLY APPLICATION NUMBER ___________________ TOTAL POINTS ______________

SECTION X: RELEASE OF INFORMATION

I HEREBY AUTHORIZE THE RELEASE AND/OR EXCHANGE OF INFORMATION BETWEEEN THE KICKAPOO HEAD START/ EARLY HEAD START PROGRAM AND THE INDIVIDUAL/ AGENCIES LISTED BELOW. PARENT/GUARDIAN MUST INITIAL APPROPRIATE ITEMS. INFORMATION REQUESTED FROM/TO:

__________ HIAWATHA SCHOOL USD #415
__________ HORTON SCHOOL USD #430
__________ KICKAPOO NATION SCHOOL
__________ FACE – FAMILY AND CHILD EDUCATION
__________ SRS – SOCIAL & REHABILITATION SERVICES
__________ BROWN COUNTY SPECIAL EDUCATION CO-OP
__________ INFANT / TODDLER PROGRAM / PART C
__________ EARLY HEAD START / PARENTS AS TEACHERS PROGRAM
__________ INDIAN PUBLIC HEALTH SERVICES
__________ WOMEN, INFANT, AND CHILDREN (WIC)
__________ KICKAPOO SOCIAL SERVICES
__________ KICKAPOO HEALTH CENTER / KICKAPOO DENTAL CLINIC
__________ BROWN COUNTY HEALTH DEPARTMENT
__________MEDICAID/HEALTHWAVE
__________ PBP FAMILY HEALTH CENTER
__________ DR. METZGER SEE TO LEARN PROGRAM
__________ APPLICANT'S REGULAR DENTIST
__________ APPLICANT'S REGULAR PHYSICIAN

**I UNDERSTAND THE INFORMATION OBTAINED WILL NOT BE TRANSMITTED TO ANOTHER PARTY WITHOUT SPECIFIC WRITTEN CONSENT, OR AS OTHERWISE PERMITTED BY FEDERAL REGULATION (42 D.F.R. PART 2). I UNDERSTAND I HAVE THE RIGHT TO REVOKE THIS PERMISSION AT ANY TIME, WHICH WILL BE DONE IN WRITING. THIS RELEASE/EXCHANGE IS FOR ORAL/WRITTEN INFORMATION AND WILL EXPIRE 120 DAYS AFTER THE END OF PARTICIPATION IN THE KICKAPOO HEAD START/EARLY HEAD START PROGRAM.

SIGNATURE OF PARENT/GUARDIAN/APPLICANT: ______________________________ DATE: ______________

SIGNATURE OF PARENT/GUARDIAN/APPLICANT: ______________________________ DATE: ______________

SIGNATURE OF KICKAPOO HEAD START/EARLY HEAD START STAFF: ______________________________ DATE: ______________

SECTION XI:PARENT'S CONSENT / COOPERATION

FIELD TRIPS:

I GIVE MY CONSENT FOR MY CHILD TO PARTICIPATE IN FIELD TRIPS SUPERVISED BY AUTHORIZED STAFF OF THE KICKAPOO HEAD START / EARLY HEAD START PROGRAM. ALL PRECAUTIONS TO ENSURE THE HEALTH AND SAFETY OF MY CHILD WILL BE TAKEN.

PARENT/GUARDIAN/APPLICANT'S INITIALS: _______________ PARENT/GUARDIAN/APPLICANT'S INITIALS: _______________

PUBLICITY:

I GIVE MY CONSENT FOR MY CHILD'S PICTURE AND NAME TO BE USED IN PROMOTIONAL WAYS TO ACQUAINT THE COMMUNITY WITH THE KICKAPOO HEAD START / EARLY HEAD START PROGRAM (NEWSPAPER, NEWSLETTER, VIDEO RECORDINGS, AND OR PARENT LISTS). I WILL ALSO BE INFORMED OF SUCH USE BEFORE HAND.

PARENT/GUARDIAN/APPLICANT'S INITIALS: _______________ PARENT/GUARDIAN/APPLICANT'S INITIALS: _______________

HEALTH & DENTAL:

I AGREE TO COOPERATE WITH KICKAPOO HEAD START STAFF/ EARLY HEAD START IN TAKING MY CHILD FOR A COMPLETE HEALTH ASSESSMENT AND DENTAL EXAM. I FURTHER AGREE TO COOPERATE FOR FOLLOW-UP CARE AS APPROPRIATE.

PARENT/GUARDIAN/APPLICANT'S INITIALS: _______________ PARENT/GUARDIAN/APPLICANT'S INITIALS: _______________

AUTHORIZATION TO TREAT MINOR INJURIES OR ACCIDENTS:

I HEREBY AUTHORIZE STAFF AT KICKAPOO HEAD START/EARLY HEAD START TO ADMINISTER MEDICAL TREATMENT AND/OR FIRST AID FOR ANY MINOR INJURY OR ACCIDENT WHILE MY CHILD IS IN THEIR CARE.

PARENT/GUARDIAN/APPLICANT'S INITIALS: _______________ PARENT/GUARDIAN/APPLICANT'S INITIALS: _______________

CHILD PROTECTION SERVICES ACKNOWLEDGEMENT:

IN THE EVENT THAT KICKAPOO HEAD START/ EARLY HEAD START STAFF HAS REASON TO SUSPECT THE OCCURRENCE OF PHYSICAL, SEXUAL, OR EMOTIONAL ABUSE, NEGLECT, OR EXPLOITATION OF A CHILD, KICKAPOO HEAD START/EARLY HEAD START STAFF WILL, AS REQUIRED BY LAW, REPORT THE INCIDENT IMMEDIATELY BY TELEPHONE OR WRITING TO THE APPROPRIATE AGENCY (KICKAPOO SOCIAL SERVICE OR SOCIAL AND REHABILITATION SERVICES).

PARENT/GUARDIAN/APPLICANT'S INITIALS: _______________ PARENT/GUARDIAN/APPLICANT'S INITIALS: _______________

CONFIDENTIALITY:

APPLICANTS' RECORDS SHALL BE CONFIDENTIAL. STAFF SHALL NOT DISCLOSE OR DISCUSS PERSONAL INFORMATION REGARDING MY CHILD WITH ANY PERSON NOT AUTHORIZED. EACH APPLICANT'S RECORD SHALL BE MADE AVAILABLE TO THE CHILD'S PARENT/GUARDIAN ON REQUEST DURING NORMAL WORKING HOURS.

PARENT/GUARDIAN/APPLICANT'S INITIALS: _______________ PARENT/GUARDIAN/APPLICANT'S INITIALS: _______________

CHILD DEVELOPMENT:

I HEREBY GIVE MY PERMISSION FOR THE KICKAPOO HEAD START / EARLY HEAD START STAFF TO EVALUATE MY CHILD'S DEVELOPMENT. THE INFORMATION WILL BE USED TO PROVIDE MY CHILD WITH INDIVIDUAL ASSISTANCE WHEN NECESSARY.

TRANSPORTATION SERVICES: (HEAD START ONLY) I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PROVIDE KICKAPOO HEAD START PROGRAM WITH A CONSISTENT PICK-UP AND DROP-OFF LOCATION. CHANGES TO THESE LOCATIONS ARE ONLY TO BE MADE IN EMERGENCY SITUATIONS OR CHANGE IN WORK/SCHOOL SCHEDULE. IF A CHANGE MUST BE MADE, I AGREE TO CONTACT THE KICKAPOO HEAD START PROGRAM AS SOON AS I AM AWARE OF THE NEED TO CHANGE THE LOCATION. PARENT/GUARDIAN'S INITIALS: _______________ PARENT/GUARDIAN'S INITIALS: _______________
TRANSPORTATION SERVICES PART II: (HEAD START ONLY) I UNDERSTAND THAT IT IS MY RESPONSIBILITY AS A PARENT TO HAVE MY CHILD READY FOR THE SCHEDULED BUS PICK UP TIME, GIVE OR TAKE 5 MINUTES, THAT HAS BEEN PROVIDED TO ME BY THE KICKAPOO HEAD START PROGRAM. I AM AWARE THAT THE SCHOOL BUS WILL NOT WAIT MORE THAN 3 MINUTES FOR MY CHILD TO GET ON THE BUS; WAITING LONGER THAN 3 MINUTES WILL DELAY THE ROUTE. I UNDERSTAND IF MY CHILD SHOULD MISS THE BUS, IT IS MY RESPONSIBILITY TO BRING MY CHILD TO KICKAPOO HEAD START. MISSING THE BUS IS NOT AN EXCUSED ABSENCE. PARENT/GUARDIAN'S INITIALS: _______________ PARENT/GUARDIAN'S INITIALS: _______________
TRANSPORATION SERVICES PART III: (HEAD START ONLY) I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO ENSURE THAT AN ADULT IS PRESENT AT THE HOME WHEN MY CHILD IS SCHEDULED TO BE DROPPED OFF. A CHILD WILL NOT BE ABLE TO GET OFF THE BUS UNTIL AN ADULT IS WAITING AT THE DOOR. IF AN ADULT IS NOT PRESENT FOR DROP-OFF, KICKAPOO HEAD START STAFF WILL CONTACT SOCIAL SERVICES. IF THEY CANNOT BE REACHED, STAFF WILL TAKE YOUR CHILD TO THE KICKAPOO POLICE DEPARTMENT. PARENT/GUARDIAN'S INITIALS: _______________ PARENT/GUARDIAN'S INITIALS: _______________
ATTENDANCE: IF ENROLLED IN THE HEAD START PROGRAM, I UNDERSTAND THAT MY CHILD NEEDS TO ATTEND HEAD START EVERYDAY WHILE SCHOOL IS IN SESSION UNLESS THEY ARE SICK OR DUE TO FAMILY EMERGENCIES. IF ENROLLED IN EARLY HEAD START, I UNDERSTAND THAT MY CHILD AND MYSELF MUST BE PRESENT EACH WEEK FOR OUR HOME VISIT, UNLESS THEY ARE SICK OR THERE IS A FAMILY EMERGENCY. IF MY CHILD MUST BE ABSENT OR I MUST CANCEL A HOME VISIT, IT IS MY RESPONSIBILITY TO CONTACT KICKAPOO HEAD START STAFF. PARENT/GUARDIAN/APPLICANT'S INITIALS: _______________ PARENT/GUARDIAN/APPLICANT'S INITIALS: _______________
PARENT PARTICIPATION: I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO BE ACTIVELY INVOLVED IN MY CHILD'S EDUCATION. I WILL COOPERATE WITH KICKAPOO HEAD START STAFF WHEN REQUESTED TO DISCUSS MY CHILD'S EDUCATION AND DEVELOPMENT. PARENT/GUARDIAN'S INITIALS: _______________ PARENT/GUARDIAN'S INITIALS: _______________

I ATTEST THAT THE INFORMATION I PROVIDED FOR THE COMPLETION OF THIS APPLICATION, EITHER WRITTEN OR VERBAL, AND ALL ATTACHMENTS ARE TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND RECOLLECTION. I UNDERSTAND THAT THIS INFORMATION IS SUBJECT TO VERIFICATION AND I REALIZE THAT DELIBERATE FALSIFICATIONS OR MISREPRESENTATION MAY RESULT IN THE REJECTION OF MY APPLICATION, AND MAY SUBJECT ME TO PROSECUTION UNDER APPLICABLE STATE AND FEDERAL LAW. I ALSO UNDERSTAND THAT THE INFORMATION IN THIS APPLICATION WILL BE HELD IN STRICT CONFIDENCE WITHIN THE PROGRAM AND IS ACCESSIBLE TO ME DURING NORMAL BUSINESS HOURS. I FURTHER UNDERSTAND THAT THIS IS ONLY AN APPLICATION FOR ASSISTANCE OF SERVICES & THAT KICKAPOO HEAD START / EARLY HEAD START IS NOT OBLIGATED TO PROVIDE ASSISTANCE TO ME.

APPLICANT/PARENT/GUARDIAN'S SIGNATURE ____ DATE ______________________

HEAD START / EARLY HEAD START ONLY – CHILD'S OR PREGNANT MOTHER'S INFORMATION ONLY. INCLUDE A SEPARATE PAGE 7 FOR EACH APPLICANT.

PRIMARY INSURANCE COVERAGE: PRIVATE _____ TITLE XIX (MEDICAID) _____ TITLE XXI (HEALTHWAVE) _____ MEDICARE _____

MILITARY _____ I.H.S. _____ **ATTACH A COPY OF THE INSURANCE CARD.

INSURANCE PLAN #/CASE # ______________________________

INSURANCE COMPANY ______________________________

INSURANCE POLICYHOLDER ______________________________

PRIMARY DOCTOR'S NAME ______________________________

ADDRESS ______________________________

PHONE NUMBER __________-__________-__________

DENTAL INFORMATION **ATTACH A COPY OF THE INSURANCE CARD.

INSURANCE PLAN ______________________________

INSURANCE POLICY HOLDER ______________________________

PRIMARY DENTIST'S NAME ______________________________

ADDRESS ______________________________

PHONE NUMBER __________-__________-__________

ANY OTHER MEDICAL CONDITIONS (CONCERNED OR SUSPECTED):

ANY SOCIAL SERVICE CONCERNS:

EMERGENCY CONTACTS:

PRIMARY CONTACT

1)______________________________ RELATION______________________________

ADDRESS ______________________________

PHONE NUMBER ______________________________

SECONDARY CONTACT

2)______________________________ RELATION______________________________

ADDRESS ______________________________

PHONE NUMBER ______________________________

SECONDARY INSURANCE COVERAGE: PRIVATE _____ TITLE XIX (MEDICAID) _____ TITLE XXI (HEALTHWAVE) _____ MEDICARE _____

MILITARY _____ I.H.S. _____ **ATTACH A COPY OF THE INSURANCE CARD.

INSURANCE PLAN #/CASE # ______________________________

INSURANCE COMPANY ______________________________

INSURANCE POLICYHOLDER ______________________________

SPECIAL CONDITIONS:

POTENTIAL OR SUSPECTED DISABILITY ______________________________

DIAGNOSED DISABILITY ______________________________

DIAGNOSIS DATE ______________________________

POTENTIAL OR SUSPECTED ALLERGIES ______________________________

REACTION ______________________________

DIAGNOSIS DATE ______________________________

IN ORDER TO MEET ALL LEGAL REQUIREMENTS, I HEREBY AUTHORIZE KICKAPOO HEAD START / EARLY HEAD START PROGRAM STAFF, TO GIVE CONSENT FOR ANY AND ALL NECESSARY EMERGENCY MEDICAL CARE FOR MY CHILD: **THIS AUTHORIZATION IS VALID FOR UP TO ONE YEAR FROM THE DATE OF NOTARIZED SIGNATURE.**

CHILD'S NAME______________________________ DOB______________________

PARENT'S SIGNATURE ______________________________ DATE_____________________

STATE OF KANSAS COUNTY OF ______________________________

BEFORE ME, THE UNDERSIGNED AUTHORITY, ON THIS DAY PERSONALLY APPEARED ______________________________ KNOWN TO BE AS THE PERSON WHOSE NAME IS SUBSCRIBED ABOVE, AND ACKNOWLEDGED TO ME THAT HE/SHE EXECUTED THE SAME FOR THE PURPOSE THEREIN EXPRESSED.

SWORN AND SUBSCRIBED BEFORE ME THIS _________ DAY OF ____________, 20_________.

______________________________NOTARY PUBLIC AND FOR _____________ COUNTY, KS

MY COMMISSION EXPIRES ______________________________

(SEAL)

*HEAD START DIRECTOR CAN NOTARIZE THIS FORM IF SIGNED IN HER PRESENCE.