Tohono O'odham Nation
Division of Early Childhood Development/Head Start Application
STUDENT TRACKING FORM

Child's Name: _____Center/Home Based Area: _____

The following checklist will assist the program in monitoring your application to completion. Your application will be processed when all applicable items have been received with complete information and signature.

Required documents for enrollment process	**Initial and date if document(s) are in the file**	**NEEDED DOCUMENTS** ***(Missing information request below)***	**Notes/Comments**
Application Form			
Birth Certificate-proof of age			
Income Guideline Form			
Income Verification Form			
Proof of Income ***(pay check stub, AFDC, written statement, DES/Zero Income Form)***			
Parental Consent for Health Services Form			
Health History-General Health History Page 1			
Health History-General Health History Page 2 ***(Social, emotional, nutrition)***			
Tribal Enrollment Letter			
Immunization Document ***Before your child is placed on a class list, copy of your child's current immunization records must be received by the program according to the State of Arizona Immunizations requirements. All immunizations must be recorded by showing a date given and signature or stamp verification by health care provider. If your child does not have an immunization record or has not received all required immunizations, call your health care provider as soon as possible to obtain a record or make an appointment for your child to receive these immunizations.***			***Please make sure you schedule appointment (or update) Immunizations for the new school year as soon as possible.***
Guardianship Document (If applies)			
Documents NEEDED once your child is accepted and enrolled			
Well Child /Physical Exam ***A health assessment (physical examination) by a physician is required. This exam should include Hemoglobin/Hematocrit (blood work), Hearing and Vision Screenings, Height & Weight, TB Assessment and/or test if at risk, Tobacco, and Lead Test. If you do not have a copy of a current physical exam for your child, you will be asked to take your child to the doctor and submit a copy for enrollment.***			***Please make sure you schedule appointment (or update) Well Child/Physical for the new school year as soon as possible.***
Dental Exam ***A dental exam by a dentist is required. If you do not have a copy of a current dental exam for your child, you will be asked to take your child to the dentist within 90 days of the first day of school to obtain one.***			***Please make sure you schedule appointment (or update) Dental exam for the new school year as soon as possible.***
Social Security Card Verified			
Insurance/AHCCCS verification			
IFSP (Individual Family Service Plan) ***IEP (Individual Education Plan)***			
Emergency Contact Form (Form given at the time of enrollment intake.)			

Tohono O'odham Nation
Division of Early Childhood Development/Head Start Application
STAFF LOG-FILE CONTROL SHEET

Child's Name: _____ Center/Home Based Area: _____

Please Sign In

Date	Name	Position/Title	Documentation Notes **(Please be specific when documenting your notes for the following areas)** *Administration and Enrollment* *Health/Disabilities* *Education* *Family and Community* *Other*
Jan 1, 2016 (Sample)	*TBautista*	*Center Coordinator Sells*	*Parent, Melissa came in to do enrollment intake for her child Jon Doe, application forms are complete but still missing documents for the file. Melissa*
was given	*student tracking sheet*	*with the documents*	*Still missing. Melissa will bring in the missing documents as soon as she can.*

Tohono O'odham Nation
Division of Early Childhood Development
Program Year 2018-2019
HEAD START APPLICATION

☐ **New** ☐ **Returning** ☐ **3rd Year** **Center/Home Based Area:** _____

Child's Name: _____ **Date of Birth:** _____ **Gender:** ☐ **F** ☐ **M**

Social Security Verified: ☐ **Yes** ☐ **No** **Primary Language Spoken:** ☐ **English** ☐ **O'odham** ☐ **Other:**_____

Insurance/AHCCCS: ☐ **Yes** ☐ **No** **Is child receiving services from WIC?** ☐ **Yes** ☐ **No**

Child's Race/Ethnicity: ☐ **Caucasian** ☐ **Hispanic/Latino** ☐ **Asian** ☐ **Hawaiian/other Pacific Islander** ☐ **African American**

☐ **American Indian/Alaskan Native** **Tribe:** _____ **Enrollment Number:** _____

IF BOTH PARENTS ARE LISTED ON THE BIRTH CERTIFICATE, PLEASE FILL OUT BOTH SECTIONS BELOW

A. PRIMARY PARENT INFORMATION

Name: _____

Gender: (Please circle) F M

Relationship to child:

☐ Biological Parent ☐ Adoptive Parent ☐ Step parent

☐ Legal Guardian ☐ Foster Parent Other: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living with partner

Does the child live with this parent?

☐ All of the time ☐ Some of the time ☐ No

Address: _____

Direction to your home: _____

_____

Home Phone: _____ **Cell:** _____

Employer: _____ *(if applicable)*

Occupation: _____

Work Phone: _____

Other: ☐ Unemployed ☐ Student ☐ Stay at home parent ☐ Disabled/Retired

Email Address: _____

Primary Language: _____

Secondary Language: _____

Message Contact Person and Number:

_____

B. SECONDARY PARENT INFORMATION

Name: _____

Gender: (Please circle) F M

Relationship to child:

☐ Biological Parent ☐ Adoptive Parent ☐ Step parent

☐ Legal Guardian ☐ Foster Parent Other: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living with partner

Does the child live with this parent?

☐ All of the time ☐ Some of the time ☐ No

Address: _____

Direction to your home: _____

_____

Home Phone: _____ **Cell:** _____

Employer: _____ *(if applicable)*

Occupation: _____

Work Phone: _____

Other: ☐ Unemployed ☐ Student ☐ Stay at home parent ☐ Disabled/Retired

Email Address: _____

Primary Language: _____

Secondary Language: _____

Message Contact Person and Number:

_____

C. INFORMATION ABOUT YOUR CHILD THAT WILL BEST HELP US ASSIST HIM OR HER:

We welcome children of all abilities and will coordinate with service providers to support your child. In order to best support your child in joining our program, please provide the following information:

Has your child been diagnosed with a disability or a health issue? ☐ Yes ☐ No If yes, please let us know diagnosis:

_____

Does your child have an IFSP (Individual Family Service Plan) **or an IEP** (Individual Education Plan)**?** ☐ Yes ☐ No

Has your child been involved with any community agencies or other supportive services, such as:

Community Health and Counseling Services: ☐ Yes ☐ No Child Welfare Services: ☐ Yes ☐ No

Behavioral Health: ☐ Yes ☐ No ☐ Other: _____

Do you or any other adult have concerns regarding your child: (speech, hearing, physical development, behavior, health, nutrition, etc.)?

☐ Yes ☐ No ☐ Not sure If yes, please describe concerns: _____

_____

D. ADDITIONAL FAMILY CIRCUMSTANCES AND EXPERIENCES:

At times, families may experience economic or social challenges that can create stress or hardships that may prioritize your eligibility status. Is your family experiencing any of the following?

☐ homelessness ☐ serious illness/disability ☐ alcohol/drug issues ☐ death in the family ☐ family violence

☐ child protective services ☐ foster care ☐ teen parent ☐ grandparent/great grandparent or other family member raising child

☐ caring for elderly or ill family member ☐ other: _____

I/We verify that all the information on the application is true and correct to the best of my/our knowledge. I/We also agree to contact Head Start if any of the information changes or is not current, as failure to do so could delay my child's enrollment. All information will remain confidential.

Parent(s)/Guardian(s) Signature: _____ Date ____/____/____

Head Start Staff Signature: _____ Date ____/____/____

*******************OFFICIAL USE ONLY*******************

Application Approved ☐ **Yes** ☐ ***No Comments:*** _____

☐ **Waiting List** ☐ **Other** _____

Head Start Program Manager Signature: _____ Date ____/____/____

Enrolled Child start Date: _____

Tohono O'odham Nation
Division of Early Childhood Development/Head Start Application
INCOME VERIFICATION FORM

Child's Name: _____ Center/Home Based Area: _____
Parent(s)/Guardian(s) Name: _____
TOTAL number of family members supported **ONLY** by your income, including head start child: _____
Please list below:

Family members supported by your income:	Relationship to Head Start Child:
Mother/Guardian's Income: ☐ Yes ☐ No	Father/Guardian's Income: ☐ Yes ☐ No
Hours Per Pay Period: _____ or per week: _____ Hourly Rate: _____ Weekly ☐ Biweekly ☐ Monthly ☐	Hours Per Pay Period: _____ or per week: _____ Hourly Rate: _____ Weekly ☐ Biweekly ☐ Monthly ☐
The following documents have been examined and at least one supportive document is attached: ☐ Pay Check Stubs/W-2 Forms ☐ Written Statement of Self Employment/Unemployment (From someone else other than self, outside of the home) ☐ AFDC, SSI, GA, Student Stipend ☐ Guardianship/Foster Care ☐ Child Support ☐ No income ☐ Last Year Income (returnee)	The following documents have been examined and at least one supportive document is attached: ☐ Pay Check Stubs/W-2 Forms ☐ Written Statement of Self Employment/Unemployment (From someone else other than self, outside of the home) ☐ AFDC, SSI, GA, Student Stipend ☐ Guardianship/Foster Care ☐ Child Support ☐ No income ☐ Last Year Income (returnee)

I certify to the best of my knowledge, the family and income information provided on this Income Verification Form along with all supporting documentation submitted is true.

Parent(s)/Guardian(s) Signature: _____ Date ____/____/____

*******OFFICIAL USE ONLY*******

Proof of Calculations: _____ *(Coordinator Initial)*

Monthly X 12 (Applies to DES Statements) _____ *(Office Specialist Initial)*
Bi weekly X 26
Weekly X 52
School System X 19

I certify that I have examined the following income documentation listed above:

Total Annual Income: $_____ Income/Family Unit: $_____

Total in Household: _____ Eligibility Status: _____

Age of Child: _____

***Head Start Program Manager Signature*: _____ Date ____/____/____**

Tohono O'odham Nation Division of Early Childhood Development-Head Start Program Income Guidelines Point System

2018-2019

Number in Family	100% below poverty	75% below poverty	50% below poverty	25% below poverty	Poverty	25% above poverty	50% above poverty	75% above poverty	100% above poverty	130% above poverty	Number in Family
1	$0	*$3,035*	*$6,070*	*$9,105*	$12,140	*$15,175*	*$18,210*	*$21,245*	*$24,280*	*$27,922*	1
2	$0	*$4,115*	*$8,230*	*$12,345*	$16,460	*$20,575*	*$24,690*	*$28,805*	*$32,920*	*$37,858*	2
3	$0	*$5,195*	*$10,390*	*$15,585*	$20,780	*$25,975*	*$31,170*	*$36,365*	*$41,560*	*$47,794*	3
4	$0	*$6,275*	*$12,550*	*$18,825*	$25,100	*$31,375*	*$37,650*	*$43,925*	*$50,200*	*$57,730*	4
5	$0	*$7,355*	*$14,710*	*$22,065*	$29,420	*$36,775*	*$44,130*	*$51,485*	*$58,840*	*$67,666*	5
6	$0	*$8,435*	*$16,870*	*$25,305*	$33,740	*$42,175*	*$50,610*	*$59,045*	*$67,480*	*$77,602*	6
7	$0	$9,515	$19,030	$28,545	$38,060	*$47,575*	*$57,090*	*$66,605*	*$76,120*	*$87,538*	7
8	$0	$10,595	$21,190	$31,785	$42,380	*$52,975*	*$63,570*	*$74,165*	*$84,760*	*$97,474*	8
Points	9	8	7	6	5	4	3	2	1	0	Points

Add $4,320 FOR EACH ADDITIONAL PERSON IN THE HOUSEHOLD

Income	Points	
Low income 100-75% below Federal guidelines	9	
Low income 74-50% below Federal guidelines	8	
Low income 49-25% below Federal guidelines	7	
Low income 24-00% below Federal guidelines	6	
Above income 01-25% above Federal guidelines	5	
Above income 26-50% above Federal guidelines	4	
Above income 51-75% above Federal guidelines	3	
Above income 76%-100% above Federal guidelines	2	
Above 100% above Federal guidelines	1	
Above 130% above Federal guidelines	0	
Age (By compulsory school attendance age)		
4.11 – 4.6	4	
4.5 – 4.0	3	
3.11 – 3.6	2	
3.5 – 3.0	1	
Disability		
Identified	10	
Suspected/(Section 504)	5	
Parent Status		
Foster Care	4	
Guardianship	3	
Single Parent	2	
Two Parent	1	
Other Factors		
Combination of any two or more factors Below	20	
Tohono O'odham	16	
Other Native non-tribal	14	
Non Native	12	
Multiple Social Service or Special Need	10	
Public Assistance, TANF, SSI	8	
Child eligible to return from previous program year	6	
Single Social Service or Special Need	4	
Teen Parent	2	

Statement on Recruitment:
Head Start is mandated to serve low-income and disabled children from 3 to 5 years of age. At least 51% of children/families must have income at or below the ACF income guidelines and 10% of enrollment slots must be reserved for disabled children.
No family or child will be denied admittance to the program on the basis of race, sex, national origin, religion, or disabling condition.

1. Families and children will be accepted according to the point priority allocation.
2. The program will work with the school districts to serve children with disabilities in accordance with the program's Memorandum of Agreement (MOA).
3. Generally, the program will enroll 2/5 three-year-olds and 3/5 four-year-olds.

Income Eligible – Current ACF income guidelines will be used when selecting children. The family's total annual income, before taxes, will be reviewed. Families meeting ACF guidelines will be determined income eligible.

Children with Disabilities – No less than 10% of the total number of enrollment opportunities shall be available for children with disabilities. Children with disabilities must meet eligibility requirements of their school district.

Foster Children – Family income is the amount paid to a foster family on behalf of a child. If no amount is paid to family income will be zero.

Over-Income Families – The program will not have more than 49% of its total population consisting of over-income families. Over-income families

TOTAL POINTS: _____

Center: _____

Child's Name: _____

Staff Signature: _____

Manager's Signature: _____Date: _____

TOHONO O'ODHAM NATION
HEAD START PROGRAM

ZERO INCOME FORM

(To be completed by adult household members who are claiming zero income from any source, if appropriate.)

Family Name: _____ Center/Home Based Area: _____

1. I hereby certify that I do not individually receive income from any of the following sources:

   a. Wages from employment (including commissions, tips, bonuses, fees, etc.);

   b. Income from operation of a business;

   c. Rental income from real or personal property;

   d. Interest or dividends from assets;

   e. Social Security payments, annuities, insurance policies, retirement funds, pensions, or death benefits;

   f. Unemployment or disability payments;

   g. Public assistance payments;

   h. Periodic allowances such as alimony, child support, or gifts received from persons not living in my household;

   i. Sales from self-employed resources (Avon, Mary Kay, Shaklee, etc.);

   j. Any other source not named above.

2. Choose one:

   ☐ Currently, I have no income of any kind and while I am seeking employment, there is no definite job offer at this time.

   ☐ Currently, I have no income of any kind and I will not be seeking employment at this time.

3. I will be using the following sources of funds to pay for rent and other necessities:

   _____

   _____

   _____

I certify that the information presented in this certification is true and accurate to the best of my knowledge.

Signature of Applicant _____

Printed Name of Applicant _____ **Date ____/____/____**

Tohono O'odham Nation
Division of Early Childhood Development/Head Start Application
EMERGENCY CONTACT FORM

Child's Name: _____ Center/Home Based Area: _____

All children enrolled in the Tohono O'odham Head Start centers will be signed in and out of centers daily. To ensure the safety of your child, he/she will NOT be released to ANYONE, known or unknown to staff unless you have listed them on the Emergency Contact Form. Please understand that this is the PARENT'S/Guardians responsibility to communicate with the authorized people listed. Please also consider the following to ensure the safety of your child:

1) *You have contacted 2 or more individuals who have agreed to be the Emergency Contact Form and accept parental responsibility for child listed above in the event that parents/guardians are not able to be reached.* ***The individuals must be 18 years or older.***
2) *Parents/Guardians will take this form to their Emergency Contact individuals for their signatures to confirm that they are accepting the responsibility of being on the Emergency Contact Form.*
3) *You understand that it's your responsibilities as parents/guardians to share the Parent Handbook with your authorized Emergency Contact individuals, so they are aware of what is expected of them as the Emergency Contact person.*
4) *You understand that your child will not be able to start school until the Emergency Contact Form is completed and returned to the assigned Head Start Center that your child is enrolled at.*
5) *No child will be released to an individual under the influence of any substance such as alcohol/drugs.*
6) *Please select responsible emergency contact individuals with local working numbers and if there are any changes, please notify your child's teacher as soon as possible.*

Child will only be released to the following persons:

Print Name:	Relationship to child:	Phone Numbers: *(work, home, cell)*	Signature of authorized person
Print Name:	Relationship to child:	Phone Numbers: *(work, home, cell)*	Signature of authorized person
Print Name:	Relationship to child:	Phone Numbers: *(work, home, cell)*	Signature of authorized person
Print Name:	Relationship to child:	Phone Numbers: *(work, home, cell)*	Signature of authorized person

*If more you want to add more individuals to form, please list on the back of this form.

My/Our signature indicates that I/We understand the content of this form and that Tohono O'odham Head Start Center, *(list center)* _____ will contact these authorized individuals listed above in such cases that I/we are not available. I/We also understand that the Emergency Contact Form is only valid for the school year 2017-2018, and if there are any changes that need to be made or updated, I/We will contact the Head Start Center or the Classroom teacher for such changes.

Parent(s)/Guardian(s) Signature: _____ Date ____/____/____

Head Start Staff receiving Emergency Contact Form:
Signature: _____ Date ____/____/____

Center/Home Based Area: _____

Child's Name: _____ Birth Date: _____

REQUIRED HEALTH ASSESSMENTS

WELL CHILD/PHYSICAL EXAM (Date of Last Well Child/Physical Exam: _____)
IMMUNIZATIONS (Date of Last Immunizations: _____)
DENTAL EXAM (Date of Last Dental Exam/Screening: _____)

MEDICATIONS

LIST ALL MEDICINES, PRESCRIPTIVE AND NON-PRESCRIPTIVE, THAT YOUR CHILD TAKES REGULARLY

Your child will not be given medication at school without a physician's note/prescription

_____

ALLERGIES AND SPECIAL DIETS

LIST ALL ALLERGIES (FOOD OR OTHER)

Has your child been prescribed medication for an allergic reaction? □ Yes □ No

If yes, please explain _____

List special diets to accommodate for cultural preference or for religious or medical reasons (indicate what specific foods are included)

_____

NUTRITION INFORMATION

Does your child experience any of the following symptoms while and/or after eating? □ Yes □ No

□ Diarrhea □ Vomiting □ Itching □ Difficulty Swallowing

If yes, please explain: _____

_____

Does your child eat any of the following: □ Yes □ No

□ Dirt □ Clay □ Laundry Soap □ Paint Chips □ School Paste/Glue □ Ice Chips □Pencils/Eraser Other: _____

SPECIAL HEALTH NEEDS / CHRONIC ILLNESS

Asthma □ Yes □ No Diabetes □ Yes □ No Anemia □ Yes □ No Seizures □ Yes □ No
Pediatric First Aid Needs □ Yes □ No Other Specific Health Needs □ Yes □ No

If yes, please explain:

_____

_____

BIRTH HISTORY

Was your child premature? □ Yes □ No

Mother's Health status: □ Good □ Fair □ Poor Father's Health status: □ Good □ Fair □ Poor

Did mother have health problems during pregnancy or delivery? □ Yes □ No

While in the hospital, did your child experience any health complications? □ Yes □ No

Was your child exposed to cigarette smoke? □ Yes □ No

If yes, please explain: _____

_____

EARS AND EYES

Any trouble hearing? □ Yes □ No Use a hearing device? □ Yes □ No

Any trouble with eyes? □ Yes □ No has ever worn glasses? □ Yes □ No

If yes, please explain: _____

_____

SOCIAL – EMOTIONAL DEVELOPMENT

Is there anything about your child's behavior that worries you? □ Yes □ No Explain: _____

_____

Does your child have a problem getting along with other children the same age? □ Yes □ No

Explain: _____

Is your child aggressive? □ Yes □ No Explain: _____

Are they Anxious? □ Yes □ No Explain: _____

Does your child have any fears or worries? □ Yes □ No Explain: _____

Does your child understand appropriate ways to express feelings? For example, anger, sad, happy, etc.

□ Yes □ No Explain: _____

Does your child understand how and when to apologize? □ Yes □ No Explain: _____

_____

Can your child identify feeling in oneself and others? □ Yes □ No Explain: _____

_____

DISABILITIES

Does your child have an Individualized Education Plan (IEP)? □ Yes □ No

Does your child have an Individual Family Service Plan (IFSP)? □ Yes □ No

Other concerns you and/or your doctor may have regarding speech, hearing, vision or any physical concerns:_____

_____

_____

Parent(s)/Guardian(s) Signature: _____ Date ____/____/____

Head Start Staff Signature: _____ Date ____/____/____

Tohono O'odham Nation
Division of Early Childhood Development/Head Start Application

CONSENT FOR HEALTH SERVICES

Child's Name: _____ **Center/Home Based Area:** _____

I/We _____ **hereby give my consent for the child listed below to receive the screening tests and examinations initialed below; I/We understand these services are deemed necessary or advisable by the Tohono O'odham Head Start Program and that I/We will be informed of any results that are abnormal.**

I/We also understand that it is my/our responsibility to provide Tohono O'odham Head Start with an up-to-date immunization record, physical/well child and dental examinations when necessary. This consent is valid for one (1) year and after the signed date. The purpose of this consent has been explained to me. I agree: _____
Initial

That in case of emergency or if a parent/guardian cannot be contacted, Tohono O'odham Head Start may provide first aide or emergency care if needed: ☐ **YES** ☐ **NO**

Initial Below:

Developmental Screening _____ **Height and weight** _____

Speech Screening _____ **Vision Test/Screening** _____

Hearing Test _____

Emergency Health Care for accidents/illness _____

Behavior/Mental Health Services including evaluation and treatment _____

Transportation to and/or from a health facility for any of these services _____

Brushing teeth daily with fluoride toothpaste _____

I/We request that you follow these special instructions:

_____

_____

Parent(s)/Guardian(s) Signature: _____ **Date** ____/____/____

Head Start Staff Signature: _____ **Date** ____/____/____