Head Start

APPLICATION CHECK LIST

Copies:

_____ Physical *Date: _____ _____ POINTS
_____ Dental *Date: _____
_____ Birth Record
_____ Shot Record
_____ Insurance _____ IE
_____ Income
_____ Custody Papers
_____ Care Plan/Allergy _____ OI
_____IEP/IFSP or Speech/Occupational/Physical Therapy

Forms: (All need to be completed)

_____ Release to form
_____ Bus Policy for Field Trips
_____ 4 Page Health Form
_____ Lead & Hemoglobin Permission Form
_____ Lead Poisoning Assessment
_____ Permission and Policy Form
_____ CACFP Enrollment Form
_____ Ethnic and Racial Data Form
_____ Information Form
_____ CSBG Form (include all family members and Social Security numbers)

CHILD'S NAME _____BIRTHDATE: _____

PHONE: _____

PARENT NAME: _____

ADDRESS: _____

AGE: _____

COMMENTS: _____

Sibling in Head Start? _____EHS? _____

RELEASE FORM FOR HCCAO HEAD START /EHS Infant and Toddler Classrooms

Child's First Name: _____ Middle: _____ Last Name: _____

Parents' /Guardians' Name: _____

Home Phone: _____ Cell #: _____ Work #: _____

Home Address:

_____

EMERGENCY CONTACTS:

Please note that these contacts may be called and do have permission for your child to be released to, if you cannot be reached. (Contacts will be called in order that they are listed.)

1. Name: _____ Address: _____

Relationship to child: _____ Phone #: _____

Date name added: _____ Initials: _____

2. Name: _____ Address: _____

Relationship to child: _____ Phone #: _____

Date name added: _____ Initials: _____

3. Name: _____ Address: _____

Relationship to child: _____ Phone #: _____

Date name added: _____ Initials: _____

4. Name: _____ Address: _____

Relationship to child: _____ Phone #: _____

Date name added: _____ Initials: _____

5. Name: _____ Address: _____

Relationship to child: _____ Phone #: _____

Date name added: _____ Initials: _____

PARENT'S SIGNATURE _____ DATE: _____

Highland County Community Action Organization, Inc
School Bus Policy

HCCAO Head Start offers bus transportation when possible for eligible children. Children and families must follow all the HCCAO Head Start rules as listed below, in the Parent Handbook and as explained by the bus driver.

1. Your child may be transported to and from a school-approved, specified location to the appropriate school each school day.
2. Only Head Start children, parents, staff, and volunteers may ride in Head Start buses. Parents are welcome to ride on the bus to school if room is available.
3. All children must remain in their Child Restraint Systems (CRS) while being transported. If your child will not stay in their CRS, the bus driver will first discuss the issue with the parent and document for the child's file. If improvement does not occur, Center Manager or Transportation Manager will then contact the parent to make alternate transportation arrangements. Bus transportation may resume once the child is able to stay in the CRS.
4. There will be no smoking on the bus or in the immediate area of the bus at any time.
5. Please do not send backpacks, toys, umbrellas, or other objects with your child on the bus due to safety issues. If you need to send anything (change of clothes, forms, etc.) give them to the bus driver, so it can be secured on the bus.
6. **Children must be brought all the way to the bus door at time of pick up. At drop off they are to be met at the bus door by a parent/guardian or person 16 years old or older that is listed on the Transportation Form.**
7. You/responsible person and your child must be at the Designated Point of Safety (DPOS) **10 minutes** before the scheduled bus pick-up time and the scheduled drop-off time. If you are not at the DPOS at the designated time the bus will leave and you will need to bring the child to the center or pick them up at the center.
8. You and your child must stay at the Designated Point of Safety (DPOS) until the bus driver instructs you and the child to approach the bus during pick-up. At drop-off, you and your child must stay at the DPOS until the bus has left the stop.
9. The bus will stop only at designated locations. The driver will not stop between pick-up/drop-off locations to discharge children.
10. If there is a change in your telephone number, or number that you can be reached at, you are required to notify us right away. We must have a current working number for emergency situations.
11. If requesting a different pick-up or drop-off location you will need to complete the Transportation Form and return it to your driver or center for consideration/approval. It may take three (3) days for this process. Not all changes are guaranteed to have bus service.
12. If your child is sick or will not be riding the bus, please contact the center prior to the scheduled pick-up time.
13. In the event a child is taken home and there is no approved person to receive the child, the driver will contact the center and then continue on with the route. At that time the Center Manager or Transportation Manager will attempt to contact you by phone. If you can not be reached we will attempt to contact someone who is listed on the Transportation Form. Whoever is contacted will need to pick-up the child at the Head Start Center.
14. If all attempts to contact someone have failed, and no one is contacted or has arrived within 2 hours of the child's dismissal time, the Center Manager or Transportation Manager will contact the Highland County Sheriff's Department or the local police.

I, _____, am the guardian of
Please Print Name

_____, a minor child
Please Print Name

receiving transportation services provided by Highland County Community Action Organization, Inc. I have read and understand the procedures that apply to transportation and I consent and agree to abide by them. I have received a copy of these procedures and am aware that they are also located in the Parent Handbook.

_____ _____
Please Sign Date

ARRIVAL AND DEPARTURE POLICY

Upon arrival, staff will transition children to the classrooms.
At time of departure, staff is responsible for taking children to designated buses.

SELF-TRANSPORT OR PARENT/GUARDIAN PICK-UP OR DROP-OFF

Parent/Guardian must sign child in/out on Sign-In/Out Log located in the child's classroom.

Ohio Department of Children and Youth

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name	Date of Birth	First Day at Program/Home
Home Address		City
State	Zip Code	Home Telephone Number

Parent/Guardian Name #1	Relationship to Child
Home Address ☐ Same as Child's	Home Telephone Number ☐ Same as Child's
City	State / Zip
Email Address *(if applicable)*	Cell Phone *(if applicable)*
Parent's Work/School Name	Parent's Work/School Telephone Number
Parent's Work/School Address	City

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Parent/Guardian Name #2	Relationship to Child
Home Address ☐ Same as Child's	Home Telephone Number ☐ Same as Child's
City	State / Zip
Email Address *(if applicable)*	Cell Phone
Parent's Work/School Name	Parent's Work/School Telephone Number
Parent's Work/School Address	City

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name	Name
City / State	City / State
Telephone Number / Relationship to Child	Telephone Number / Relationship to Child
Other numbers where emergency contact can be reached *(if applicable)*	Other numbers where emergency contact can be reached *(if applicable)*

Name of Physician or Clinic/Hospital		
Street Address		
City	State	Telephone Number

Child's Name

Allergies, Special Health or Medical Conditions, and Medical Foods

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the DCY 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - *check all that apply* ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a DCY 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a DCY 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

☐ No

☐ Yes - a DCY 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a DCY 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on file.

☐ N/A - program does not provide meals or snacks to the child.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

☐ Not applicable

Child's Name

Diapering Statement

Is your child toilet trained? ☐ Yes *(If yes, skip to Emergency Transportation Authorization section)*
☐ No (If no, fill out the following:)

The program's policy is to check diapers every 2 hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give *Permission* to Transport		**OR** Do not sign both	***Do Not Give Permission*** **to Transport**	
Program or Home Name HCCAO HS/EHS			Program or Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.			**does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date		Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐Yes ☐No *(check one)*

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note:
This is a prescribed form which must be used by child care providers to meet the requirements to rules 5180:2-12-15, 5180:2-13-15, and 5180:2-14-04.

This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Reset Form

HCCAO HEAD START/EARLY HEAD START

Lead & Hemoglobin Permission Form

Dear Parent/Guardian:

HCCAO Head Start/Early Head Start and WIC will be offering lead and hemoglobin screenings to children enrolled. The Health Services Manager for Head Start/Early Head Start and a nurse from the WIC office will perform these services.

In order for your child to participate, your signature and insurance information is required. Your signature will allow us to perform the test one time during the school year.

If your child has already received the lead and hemoglobin screenings, we will need a copy of these screenings from your doctor. If we do the screenings, a copy of the results will be sent to you.

Child's Information (Please Print)

Name_____ Date of Birth ____/____/____

Address_____

City_____State_____ Zip Code_____

Social Security Number # (Required) _____

Home Phone # _____

Please Check One (Please Print)

Name of Insurance _____ Medicaid ____ Private Insurance ____No Insurance____

- If you have private insurance, you will be notified of the date due to a $15.00 fee for lead test

Parent/Guardian Name_____ Date of Birth ___/___/___

Parent Signature_____ Date_____

CBC BLOOD LEAD POISONING RISK ASSESSMENT QUESTIONAIRE

CHILD'S NAME: _____

1. Does your child live or regularly visit a house built before 1960? ☐ Yes ☐ No ☐ Unsure
2. Was your child's daycare center or babysitter's home built before 1960? ☐ Yes ☐ No ☐ Unsure
3. Does your home have peeling, chipping, dusting, or chalking paint? ☐ Yes ☐ No ☐ Unsure
4. Have any of your children's playmates had lead poisoning? ☐ Yes ☐ No ☐ Unsure
5. Does your child frequently come in contact with an adult who works with lead? (example: construction, pottery, welding, etc) ☐ Yes ☐ No ☐ Unsure
6. Does your child live near a lead smelter, battery recycling plant, or other industry likely to release lead? ☐ Yes ☐ No ☐ Unsure
7. Do you give your child any home or folk remedies which may contain lead? ☐ Yes ☐ No ☐ Unsure
8. Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead? ☐ Yes ☐ No ☐ Unsure
9. Does your child drink well water? ☐ Yes ☐ No ☐ Unsure
10. Does your home have lead or copper pipes that are soldered with lead? ☐ Yes ☐ No ☐ Unsure

****If you have answered "Yes" or "Unsure" to any of the above questions your child may be at risk for Lead Poisoning.**

****Lead Screenings on all children should occur at age 1 and 2 years old, or up to 6 years of age if no test has been administered.**

There is no safe level of lead in the blood. Any confirmed level of lead in the blood is a reliable indicator that the child has been exposed to lead.

Parent/Guardian Signature that completed questionnaire:

_____ **Date:** _____

HEAD START/ EARLY HEAD START

(Permission and Policy Form)

CHILD'S NAME: _____ CHILD'S BIRTHDATE: _____

1. I give Head Start and Early Head Start permission for my child to appear in photographs, films, local cable T.V. shows, newspapers, and videos. ___ yes ___ no

2. I give Head Start and Early Head Start my permission to release information from Help Me Grow and Job & Family Services for verification of cash assistance, food assistance and child support benefits. ___ yes ___ no

3. I give Head Start and Early Head Start my permission for my child to participate in all Head Start and Early Head Start screenings mandated by the Federal Performance Standards, during the school year in which my child is enrolled. (Height, weight, vision, hearing, speech, educational, and developmental.) ___ yes ___ no

4. I give my permission to Head Start and Early Head Start to have my child's health record and screening results sent to the appropriate public school or any other agency. ___ yes ___ no
(PLEASE LIST CHILD'S SCHOOL DISTRICT _____.)

5. I give my permission for Head Start/Early Head Start to provide mental health consultation services. ___ yes ___ no

6. I give my permission for Head Start and Early Head Start to obtain medical and dental information from any physician or dentist office and any hospital or clinic my child has been a patient. ___ yes ___ no

7. I give Head Start and Early Head Start my permission to have my child's personally identifiable information (name, birthdate, phone number, address, etc.) sent to my child's school district or other agency if requested. ___yes ____no

8. I give Head Start and Early Head Start my permission to have my child's Creative Curriculum (DRDP)) information sent to my child's school district. ___ yes ___ no

9. During Head Start and Early Head Start program reviews, all regulatory authorities could have access to review your child's file. _____ ***Parent Initials***

GRIEVANCE PROCEDURES

Grievance / complaint must be in writing and signed by the person who makes the complaint. Unsigned grievances or complaints will not be answered.

1. Grievance / complaints are then submitted to the Family Engagement Manager who will in turn give it to the Director of Early Childhood Program. If preferred the grievance / complaint may be submitted to the Director of Early Childhood Program directly.
2. The Director shall have 10 days to resolve the grievance or will present it to the Policy Council for discussion.

I give my permission for the above items and have read and understand the grievance procedures.

Signature _____ **Date** _____

Revised 2/7/22

Ohio Department of Education and Workforce - Office of Nutrition

CHILD AND ADULT CARE FOOD PROGRAM

ENROLLMENT FORM

Required Form for use by Child Care Centers and Head Start Programs

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside School Hours, Youth Development & After School at Risk

Instructions to Complete

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care.
- If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

CENTER NAME HCCAO EHS/HS

CHILD'S NAME (please print) | **AGE** | **BIRTHDATE** month / day / year

CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE AND THE MEALS RECEIVED WHILE IN CARE

Check (✓) Days Child Normally in Care	List hours child normally in care				Check (✓) meals child normally receives while in care					
	Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday	8:30			3:30	✓		✓	✓		
Tuesday	8:30			3:30	✓		✓	✓		
Wednesday	8:30			3:30	✓		✓	✓		
Thursday	8:30			3:30	✓		✓	✓		
Friday	8:30			3:30	✓		✓	✓		
Saturday										
Sunday										

☐ **Yes, the schedule listed above may frequently vary due to changes in parents/guardians schedule.**

SIGNATURE OF PARENT/GUARDIAN | **DATE** | **DAY PHONE NUMBER**

MAILING ADDRESS STREET /APT. | **CITY** | **ZIP CODE**

PARENT BIRTHDATE month / day / year | **PARENT EMAIL**

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity .Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDAOASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation.

The completed AD-3027 form or letter must be submitted to USDA by:
(1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (833) 256-1665 or (202)690-7448; or (3) email:program.intake@usda.gov.

This institution is an equal opportunity provider

Revised 8/2024

ETHNIC and RACIAL DATA FORM

Agency/Daycare Center HCCAO HS/EHS

Agency/Daycare Address _____

The agency or daycare listed above receives Federal financial assistance for participating in the Child and Adult Care Food Program (CACFP). Because they receive Federal financial assistance they are required to record and maintain the Ethnic and Racial data of all children enrolled in the CACFP. This information is used solely for the purpose of determining compliance with Civil Right laws and will be kept confidential. We are requesting for each participant to 'Self Identify' and provide this information, however it is optional to Self Identify. This ethnic and racial information will remain confidential and on file for 3 years and will only be accessible to authorized personnel.

To Self Identify, please answer the following questions.

Child's name: _____

Ethnic Category: _____

Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino".	
Non-Hispanic or Latino:	

Racial Categories: Check all that apply

American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America, (including Central America), and who maintains tribal affiliation or community recognition.	
Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.	
Black or African American: A person having origins in any of the black racial groups of Africa.	
Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.	
White: A person having origins in any of the original peoples of Europe, the Middle East or North Africa	
Other	

Parent/Guardian Signature _____ **Date**_____

H.C.C.A.O. HEAD START / EARLY HEAD START INFORMATION SHEET

Child's Name _____ DOB _____ Age_____

Mother's Name_____ DOB _____ Mother in Home? _____

Father's Name _____DOB _____ Father in Home? _____

Number in Family _____ Number in Household ____ Is the Child You are Enrolling a Foster Child? ____

Do You Have Custody Papers? _____Shared Parenting? _____

Are You a Past Head Start/Early Head Start Parent? _____

Do You Live with Someone Else? _____ Who? _____Are You Homeless? _____

Name the Other Family Members in the Home: (i.e.: siblings, grandparents, Aunts, Uncles, etc.....)

1. _____ Relationship to Child _____ DOB _____
2. _____ Relationship to Child _____ DOB _____
3. _____ Relationship to Child _____ DOB _____
4. _____ Relationship to Child _____ DOB _____

Mother's Educational Level _____ Graduated? ____ Father's Educational Level _____ Graduated? _____

Parents/Guardian in School or Training? _____ Where? _____ Grad. Date _____ Degree _____

Are You Employed? ___ Full Time _____ Part Time ____ Spouse Employed? _____ Full Time _____Part Time_____

Are You Employed Less Than One Year? _____ Spouse Employed Less Than a Year? _____

Do You Use Childcare? _____ Who? _____ Do You Have Subsidized Childcare? _____

Was Your Child in Early Head Start? ____Was Your Child in Help Me Grow? ____Do You Receive WIC? _____

Do You or Anyone in Your Family Receive SSI? _____ Who? _____ Do You Receive TANF? ____

Do You Receive OWF? _____ Do You Receive a Food Card? _____ Do You Have Medical Insurance? _____

What Kind of Insurance? _____ Were You a Teen Parent? _____ Are You Pregnant? _____

Parent/ Guardian / Spouse Incarcerated? _____

Does Your Child Have a Disability? _____ IEP _____ Does Parent / Guardian Have a Disability_____

Were You Referred by a Child Welfare Agency? _____ Who? _____

Was Your Child on a Waiting List Last Year? _____

Is Anyone in Your Family Receiving Mental Health Counseling or Treatment? _____

Do You Have Any Concerns About Your Child's Behavior? _____What? _____

How Did You Hear About the Head Start Program? _____

*_I hereby certify that all information provided in the application is true and accurate_

PARENT/ GUARDIAN SIGNATURE: _____ DATE: _____

Community Services Block Grant — Customer Intake Application

Client Number:	Agency:	Application Date:
	Highland County Community Action Org. Inc.	

Primary Applicant First Name	M.I.	Last Name

Social Security Number	Date of Birth	Gender
___/__/____	__/__/____	☐ Female ☐ Other ☐ Male

Household Information:

Household Size:	Family Type	Building Type
	☐ Single Parent/Female	☐ Mobile Home
Housing Status	☐ Single Parent/Male	☐ Single Family
☐ Own	☐ Two-Parent Household	☐ Multi-family low rise (3 stories or less)
☐ Rent	☐ Single Person	☐ Multi-family high rise (3 stories or more)
☐ Other Permanent Housing	☐ Two Adults/No Children	
☐ Homeless	☐ Non-related Adults with children	
☐ Other	☐ Multigenerational Household	
	☐ Other	

Customer Address:

Current Service Address:		Apartment/Lot/Unit Floor:	
Current Mailing Address (if different from above):		Apartment/Lot/Unit Floor:	
City:	State:	Zip Code:	County:
Phone Number:		Email Address:	
Preferred method of contact?			

Primary Applicant Demographic Information:

Ethnicity	Race	Education
☐ Hispanic, Latino or Spanish Origins	☐ American Indian/Alaskan Native	☐ Grade 0-8
☐ Not Hispanic, Latino or Spanish Origins	☐ Asian	☐ Grades 9-12/Non-Graduate
	☐ Black/African American	☐ High School Grad/GED
	☐ Native Hawaiian/Other Pacific Islander	☐ 12+ Some Post-Secondary Education
	☐ Other	☐ 2 or 4 Year College Graduate
	☐ Unknown/Not-reported	☐ Graduate or other post-secondary school
	☐ White	

Client Disabled?	Military Status	Is Client a US Citizen?
☐ Yes	☐ Veteran	☐ Yes
	☐ Active Military	

Work Status	Health Insurance Type	Non-Cash Benefits
☐ Employed full-time	☐ Medicaid	☐ Affordable Care Act Subsidy
☐ Employed part-time	☐ Medicare	☐ Childcare Voucher
☐ Migrant Seasonal Farm Worker	☐ Private/Employment Based	☐ Housing Choice Voucher
☐ Unemployed (short-term, 6 months or less)	☐ Self-Insured/Direct Pay	☐ HUD-VASH
☐ Unemployed (long-term, more than 6 months)	☐ None	☐ Other
☐ Unemployed (not in labor force)	☐ State Children's Health Insurance Program	☐ Permanent Supportive Housing
☐ Retired	☐ State Health Insurance for Adults	☐ Public Housing
☐ Unknown/not reported		☐ SNAP
☐ Youth ages 14-24 who are neither working nor in school		☐ WIC

Retain copy of application

Adult info this side – other family members on Remaining pages.

Additional Household Members

First Name	M.I.	Last Name

Social Security Number	Date of Birth	Gender
___/__/____	__/__/____	☐ Female ☐ Other ☐ Male

Ethnicity	Race	Education
☐ Hispanic, Latino or Spanish Origins ☐ Not Hispanic, Latino or Spanish Origins	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Unknown/Not-reported ☐ White	☐ Grade 0-8 ☐ Grades 9-12/Non-Graduate ☐ High School Grad/GED ☐ 12+ Some Post-Secondary ☐ Education ☐ 2 or 4 Year College Graduate ☐ Graduate or other post-secondary school

Client Disabled?	Military Status	Is Client a US Citizen?
☐ Yes	☐ Veteran ☐ Active Military	☐ Yes

Work Status	Health Insurance Type	Non-Cash Benefits
☐ Employed full-time ☐ Employed part-time ☐ Migrant Seasonal Farm Worker ☐ Unemployed (short-term, 6 months or less) ☐ Unemployed (long-term, more than 6 months) ☐ Unemployed (not in labor force) ☐ Retired ☐ Unknown/not reported ☐ Youth ages 14-24 who are neither working nor in school	☐ Medicaid ☐ Medicare ☐ Private/Employment Based ☐ Self-Insured/Direct Pay ☐ None ☐ State Children's Health Insurance Program ☐ State Health Insurance for Adults	☐ Affordable Care Act Subsidy ☐ Childcare Voucher ☐ Housing Choice Voucher ☐ HUD-VASH ☐ Other ☐ Permanent Supportive Housing ☐ Public Housing ☐ SNAP ☐ WIC

First Name	M.I.	Last Name

Social Security Number	Date of Birth	Gender
___/__/____	__/__/____	☐ Female ☐ Other ☐ Male

Ethnicity	Race	Education
☐ Hispanic, Latino or Spanish Origins ☐ Not Hispanic, Latino or Spanish Origins	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Unknown/Not-reported ☐ White	☐ Grade 0-8 ☐ Grades 9-12/Non-Graduate ☐ High School Grad/GED ☐ 12+ Some Post-Secondary ☐ Education ☐ 2 or 4 Year College Graduate ☐ Graduate or other post-secondary school

Client Disabled?	Military Status	Is Client a US Citizen?
☐ Yes	☐ Veteran ☐ Active Military	☐ Yes

Work Status	Health Insurance Type	Non-Cash Benefits
☐ Employed full-time ☐ Employed part-time ☐ Migrant Seasonal Farm Worker ☐ Unemployed (short-term, 6 months or less) ☐ Unemployed (long-term, more than 6 months) ☐ Unemployed (not in labor force) ☐ Retired ☐ Unknown/not reported ☐ Youth ages 14-24 who are neither working nor in school	☐ Medicaid ☐ Medicare ☐ Private/Employment Based ☐ Self-Insured/Direct Pay ☐ None ☐ State Children's Health Insurance Program ☐ State Health Insurance for Adults	☐ Affordable Care Act Subsidy ☐ Childcare Voucher ☐ Housing Choice Voucher ☐ HUD-VASH ☐ Other ☐ Permanent Supportive Housing ☐ Public Housing ☐ SNAP ☐ WIC

other family members here

Additional Household Members

First Name	M.I.	Last Name
Social Security Number	**Date of Birth**	**Gender**
___/__/____	__/__/____	☐ Female ☐ Other ☐ Male
Ethnicity	**Race**	**Education**
☐ Hispanic, Latino or Spanish Origins ☐ Not Hispanic, Latino or Spanish Origins	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Unknown/Not-reported ☐ White	☐ Grade 0-8 ☐ Grades 9-12/Non-Graduate ☐ High School Grad/GED ☐ 12+ Some Post-Secondary ☐ Education ☐ 2 or 4 Year College Graduate ☐ Graduate or other post-secondary school
Client Disabled?	**Military Status**	**Is Client a US Citizen?**
☐ Yes	☐ Veteran ☐ Active Military	☐ Yes
Work Status	**Health Insurance Type**	**Non-Cash Benefits**
☐ Employed full-time ☐ Employed part-time ☐ Migrant Seasonal Farm Worker ☐ Unemployed (short-term, 6 months or less) ☐ Unemployed (long-term, more than 6 months) ☐ Unemployed (not in labor force) ☐ Retired ☐ Unknown/not reported ☐ Youth ages 14-24 who are neither working nor in school	☐ Medicaid ☐ Medicare ☐ Private/Employment Based ☐ Self-Insured/Direct Pay ☐ None ☐ State Children's Health Insurance Program ☐ State Health Insurance for Adults	☐ Affordable Care Act Subsidy ☐ Childcare Voucher ☐ Housing Choice Voucher ☐ HUD-VASH ☐ Other ☐ Permanent Supportive Housing ☐ Public Housing ☐ SNAP ☐ WIC

First Name	M.I.	Last Name
Social Security Number	**Date of Birth**	**Gender**
___/__/____	__/__/____	☐ Female ☐ Other ☐ Male
Ethnicity	**Race**	**Education**
☐ Hispanic, Latino or Spanish Origins ☐ Not Hispanic, Latino or Spanish Origins	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Unknown/Not-reported ☐ White	☐ Grade 0-8 ☐ Grades 9-12/Non-Graduate ☐ High School Grad/GED ☐ 12+ Some Post-Secondary ☐ Education ☐ 2 or 4 Year College Graduate ☐ Graduate or other post-secondary school
Client Disabled?	**Military Status**	**Is Client a US Citizen?**
☐ Yes	☐ Veteran ☐ Active Military	☐ Yes
Work Status	**Health Insurance Type**	**Non-Cash Benefits**
☐ Employed full-time ☐ Employed part-time ☐ Migrant Seasonal Farm Worker ☐ Unemployed (short-term, 6 months or less) ☐ Unemployed (long-term, more than 6 months) ☐ Unemployed (not in labor force) ☐ Retired ☐ Unknown/not reported ☐ Youth ages 14-24 who are neither working nor in school	☐ Medicaid ☐ Medicare ☐ Private/Employment Based ☐ Self-Insured/Direct Pay ☐ None ☐ State Children's Health Insurance Program ☐ State Health Insurance for Adults	☐ Affordable Care Act Subsidy ☐ Childcare Voucher ☐ Housing Choice Voucher ☐ HUD-VASH ☐ Other ☐ Permanent Supportive Housing ☐ Public Housing ☐ SNAP ☐ WIC

Countable Income Information

Customer Name:	Total Amount Received	Period Received (30, 90 or 365 days)
	$	
	$	
	$	
	$	
	$	
	$	
	$	

Income Category:		Frequency:	Total Amount:
☐ Fixed	☐ SSI ☐ SSDI ☐ SSA ☐ Pension ☐ Window/Widower's benefit ☐ Adoption Assistance ☐ Alimony ☐ Black Lung pension	☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly	$ _____
☐ Earned	☐ Wages ☐ Self-employment ☐ Active Military Pay ☐ Ohio Electronic Child care	☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly	$ _____
☐ Supplemental	☐ Unemployment ☐ Utility Assistance ☐ Workers' Compensation ☐ Ohio Works First (TANF, ADC)	☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly	$ _____
☐ Other	☐ Cash withdraws from: IRA, Annuities, Other investments ☐ Lump sum payout from: SSI, SSDI, Estate & Trust settlements, Divorce settlements, insurance payout, lotter winnings ☐ Interest Income	☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly	$ _____
☐ None			$ _____
		Total:	$ _____

Deductions:

Deductible Income:	Frequency:	Total Amount:
☐ Health Insurance Premiums ☐ Health Care Spending Accounts ☐ Medicaid Spend Down (deductibles) ☐ Medicare Part D (RX premium) ☐ Child Support paid-out ☐ Attorney fees for estate or trust settlements	☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly	$ _____
	Total Household Income (Countable Income – Deductions)	$ _____
	Federal Poverty Level:	_____%

I certify that this statement is true and correct to the best of my knowledge, and I authorize the release of any or all information necessary for verification purposes.

Applicant Signature: _____ Date: _____

Approved by: _____ Date: _____

Excluded Income:	Frequency:	Total Amount:
☐ Agency Orange Pension ☐ Veterans affairs, service related disability ☐ Handicapped income (i.e. work programs for the blind or disabled) ☐ Title V wages (i.e. senior employment programs) ☐ Volunteers in Service to America Stipend (VISTA) ☐ Work allowances (work requirement to receive OWF assistance) ☐ Income earned by dependent minors ☐ Tax refunds/rebates ☐ Education assistance (grants stipends for tuition/books) ☐ Stipends for foster care ☐ Military allowances for subsistence ☐ Ohio waiver program (Medicaid benefit for caregiver) ☐ Prevention retention and contingency (i.e. emergency services, rental asst.) ☐ transportation allowances (WIOA) ☐ Proceeds from reverse mortgage ☐ FEMA, cash payments ☐ Title III Disaster relief emergency assistance	☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly	$ _____

Expense Type:	Total Monthly Expense amount:
Food	$ _____
Shelter	$ _____
Child Care	$ _____
Transportation	$ _____
Utilities	$ _____
Total:	$ _____

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*	Date of Birth

Note: Sections A and B must be completed by the examining Health Care Practitioner (Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner):

Section A- EXAMINATION

√ The above named child has been examined.

√ The above named child is in suitable condition for participation in group care (i.e. free of infectious disease, mentally and physically fit to be in group care).

√ The above named child does not have allergies OR is allergic to the following (*please list in space below*):

Check below, if applicable:

☐ Additional information that will assist the child care program in providing appropriate child care for the above named child (special health care and developmental considerations) accompanies this form.

Optional: Measurements and Recommended Assessments/Screenings

Height _____ Vision _____ ☐ Yes ☐ No Lead _____ ☐ Yes ☐ No

Weight _____ Hearing _____ ☐ Yes ☐ No Hemoglobin _____ ☐ Yes ☐ No

BMI _____ Dental _____ ☐ Yes ☐ No Other: _____

Notes:

Signature of Examining Health Care Practitioner	Date of Examination
Name of Examining Health Care Practitioner	Telephone Number
Street Address	City, State and Zip Code

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES (MM/DD/YYYY FORMAT) OF DOSES OF ALL IMMUNIZATIONS.

IMMUNIZATION (*Complete ONLY ONE SECTION below*)

Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases: Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.

Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER:	**Initials of Examining Health Care Practitioner**
☐ The above named child has been immunized against the diseases listed above. *If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):*	Date
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S): ☐ I have declined to have my child immunized for reasons of conscience, including religious convictions against all of the diseases listed above or against the following disease(s):	**Signature of Parent** Date

HIGHLAND COUNTY HEAD START

HILLSBORO • GREENFIELD • BELFAST

Dental Examination Form

CHILD'S NAME: _____ SEX: ____ BIRTH DATE: ____/____/____ AGE: _____

PARENT(S) NAME: _____ PHONE NUMBER: _____

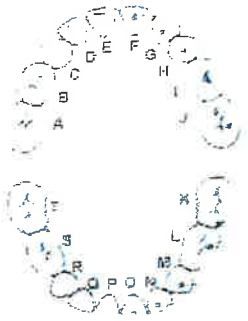
INSURANCE NUMBER (MEDICAID OR PRIVATE INSURANCE): _____

1) Diagnostic and Preventive Procedures Performed: ❑ Clinical Examinations ❑ Prophylaxis ❑ X-Rays ❑ Fluoride application ❑ Other _____

EXAMINATION AND TREATMENT RECORD:
INDICATE TEETH NEEDING TREATMENT (below on chart)

DATE OF EXAM: _____

Tooth # or letter	Description of Dental Services Required



Upper Teeth	Shed
Central Incisor	6-7 yrs
Lateral Incisor	7-8 yrs.
Canine (Cuspid)	10-12 yrs.
First Molar	9-11 yrs
Second Molar	10-12 yrs.

Lower Teeth	Shed
Second Molar	10-12 yrs.
First Molar	9-11 yrs
Canine (Cuspid)	9-12 yrs
Lateral Incisor	7-8 yrs.
Central Incisor	6-7 yrs.

2) Current Status: Cavities: _____ (How Many) Recurrent decay around old fillings: _____ (How Many)

Gums and supporting tissues: ❑ Normal & Healthy ❑ Slight inflammation (gingivitis) ❑ Moderate inflammation

❑ Advanced disease (periodontitis) Other: _____

3) Recommendation:

❑ No further treatment recommended at this time. Return in _____ months for a routine cleaning and examination.

❑ Additional dental treatment is required. Please complete the Treatment/Follow-up Plan identified below:

TREATMENT/ FOLLOW-UP PLAN

DENTAL TREATMENTS: Date: _____ Outcome: _____

Date: _____ Outcome: _____

Date: _____ Outcome: _____

Date: _____ Outcome: _____

_____
DATE ALL TREATMENT WAS COMPLETED

I Certify that I, the Dental Care Provider has completed the service(s) listed in section 1, 2, & 3 including the Follow-Up Plan(If needed).

_____ _____ _____
Dentist Name (Please Print) Signature Date

_____ _____ _____
Address, City, State & Zip Code Phone Number Fax Number

THIS FORM IS TO BE COMPLETED BY A DENTAL CARE PROVIDER.

Please fax and/or return this form to: H.C.C.A.O Head Start • PO box 838 • 1487 N. High St., Hillsboro, Ohio. 45133
(937) 393-3458 • Fax (937) 393-7175

Revised 12/2008

Good nutrition today means a stronger tomorrow!

Building for the Future with CACFP

This day care receives support from the Child and Adult Care Food Program to serve healthy meals to your children.

Meals served here must meet USDA's nutrition standards.

Questions? Concerns?

[HCCAO HS/EHS 1487 N. High St Suite 500 Hillsboro, Ohio 45133]

Learn more about CACFP at USDA's website:

https://www.fns.usda.gov/

United States Department of Agriculture
Food and Nutrition Service FNS-317
November 2019

Building For the Future

This childcare facility participates in the Child and Adult Care Food Program (CACFP), a federal program that provides healthy meals and snacks to children receiving day care.

Each day millions of children participate in CACFP at childcare homes and centers across the country. Providers are reimbursed for serving nutritious meals which meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

Meals

CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the five components)
Milk Fruit OR Vegetable Grains or Bread* *Meat/Meat Alternate may replace entire grain up to 3x/week	Milk Meat or meat alternate Grains or bread Vegetable AND Fruit or Second Vegetable (If serving two vegetables they must be different foods)	Milk Meat or meat alternate Grains or bread Fruit Vegetable

Participating Facilities

Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers**: Licensed or approved public or private nonprofit childcare centers, Head Start programs, and some for-profit centers.
- **Family Child Care Homes**: Licensed private homes.
- **After School Care Programs**: Centers in low-income areas provide free snack and/or meal to school-age children and youth.
- **Emergency Shelters**: Programs providing meals to homeless children.

Eligibility

State agencies reimburse facilities that offer non-residential day care to the following children:

- Children aged 12 and under,
- Migrant children aged 15 and younger, and
- Youths through 18 in emergency shelters and after school care programs in needy areas.

Contact Information

If you have questions about CACFP, please contact one of the following:

Sponsoring Organization/Center

HCCAO HS/EHS
1487 N. High St.
Suite 500
Hillsboro, Oh 45133

Ohio Department of Education

CACFP Program Specialist
25 S. Front Street, MS 303
Columbus, OH 43215-4183
Phone: 614-466-2945
Toll Free: 1-800-808-6235

Nondiscrimination

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.
Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.
To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. Mail: U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410;
2. Fax: (202) 690-7442; or
3. Email: program.intake@usda.gov.

02/2022