HCCAO

Early Head Start

Prenatal Application

The following information needs to be turned in along with this application:

- *Questionnaire for pregnant women*
- *Proof of pregnancy(Doctor's note, copy of prenatal visit)*
- *Copy of I.D. (Drivers License, copy of medical card, ect...)*
- *Proof of Income(Pay stub, tax form 1040, W-2, pay stub for child support, unemployment, social security, a written statement if there is no income in the home.)*
- *Dental form filled out*
- *Permission and Policy form*

Early Head Start
Questionnaire for Pregnant Women

#	Please answer each question listed below.	YES	NO
1.	Are you currently enrolled in school?		
2.	Do you have a high school diploma or GED?		
3.	Did you provide proof of pregnancy?		
4.	Did you provide proof of income?		
5.	Do you have medical coverage for your prenatal care?		
6.	Are you currently receiving prenatal care?		
7.	Have you been pregnant before?		
8.	Do you have any children less than 1 year old?		
9.	Have you had previous pregnancy complications?		
10.	Do you receive WIC for your pregnancy?		
11.	Are you homeless or in need of better housing?		
12.	Has a doctor told you that this is a high-risk pregnancy?		
13.	Do you have emotional support?		
14.	Are you a teen parent?		
15.	Is the father of your baby in the home/involved with pregnancy?		
16.	Do you smoke?		

According to Early Head Start Policies and guidelines, we are to enroll pregnant women and children who would most benefit from our services. In order to determine who receives services first, we are asking you to complete this questionnaire to the best of your ability.

The above information is true to the best of my knowledge.

_____ _____

Signature Date

Early Head Start
Prenatal Application

Name: _____ Date Of Birth _____/_____/_____ SSN: _____

Address _____

Street City/ Town Zip County

Home Phone :(_____) _____ Expected Due Date:_____

Family Information

Marital Status: (Circle One) Single, Married, Divorced, Separated, Living Together

Expectant Mothers Work / School: _____ Phone: _____

Hours Working: _____ to _____ School Grade Completed: _____

Expectant Father's Work / School: _____Phone_____

Hours Working: _____ to _____ School Grade Completed: _____

Does your Family receive any of the following services or financial assistance? (Please check all that apply)

_____ Public Assistance – OWF _____ SSI _____ Public Housing Assistance

_____ Child Support / Alimony _____ Social Security _____ Chip/ Healthy Start/ Medicaid

_____ Energy Assistance _____ Food Stamps _____ WIC

_____ Foster care / Adoption Subsidy _____ Other _____ Receiving No Services

Optional: Race: _____ White _____ Black/African American _____ American Indian

_____ Native Hawaiin _____ Biracial/Multiracial _____ Other

Ethnicity: _____ Non-Hispanic _____ Hispanic

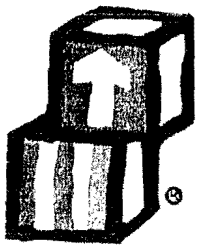
I fully understand that the above statements made are correct to the best of my knowledge. Incorrect statements could lead to my dismissal from the program.

_____ _____

Signature Date

OMB 0907-0374; Expires: 02/28/2013

Head Start Eligibility Verification



1. Child's name: _____

2. Child's date of birth: _____

3. This child is eligible to participate in the program. ☐ Yes ☐ No

4. Check the applicable category of eligibility for this child:

☐ SSI
☐ Homeless
☐ Foster Care
☐ Public assistance

☐ Income *(check box that applies):*
- ☐ *Below federal poverty guidelines*
- ☐ *Between 100-130% of federal poverty guidelines (no more than 35% of enrolled children may fall into this category)*

☐ Over- Income
- ☐ *Counted as part of 10% maximum for non-AI/AN programs)*
- ☐ *Counted as part of the 49% maximum for AI/AN programs)*

4. What documentation was used to determine eligibility?

☐ Income Tax Form 1040
☐ W-2
☐ TANF documentation
☐ Pay stub or pay envelopes
☐ Unemployment
☐ Written statements from employers
☐ Foster care reimbursement
☐ SSI documentation
☐ Other

If Other, please explain: _____

Documentation of no income: _____

5. Staff signature: _____ Date of eligibility verification: _____

6. Staff name: _____ Title: _____

CAC/CSBG INTAKE FORM

SS# _____ Last Name _____ First Name _____ DOB _____

_____ _____ _____ _____

ADDRESS *CITY* *ZIP CODE* *PHONE NUMBER*

GENDER
- ☐ FEMALE
- ☐ MALE

DISABLED
- ☐ YES
- ☐ NO

ETHNICITY
- ☐ B. Black/African Am.
- ☐ W. White
- ☐ H. Hispanic
- ☐ N. Native American
- ☐ A. Asian
- ☐ O. Other

EDUCATION
- ☐ A. 0 - 8
- ☐ B. 9 - 12 (Non grad)
- ☐ C. HS GRAD/GED
- ☐ D. 12+
- ☐ E. COLLEGE GRAD

HOUSING
- ☐ OWN
- ☐ RENT
- ☐ HOMELESS

FOOD STAMPS
- ☐ YES
- ☐ NO

HEALTH INSURANCE
- ☐ A. MEDICAID
- ☐ B. MEDICARE
- ☐ C. PRIVATE
- ☐ D. SELF INS
- ☐ E. NONE
- ☐ F. UNKNOWN

 # IN HSHLD

VETERAN
- ☐ YES
- ☐ NO

FAMILY TYPE
- ☐ F. Single par/fe
- ☐ M. Single par/ma
- ☐ T. TWO PARENT
- ☐ S. SINGLE
- ☐ C. COUPLE
- ☐ O. OTHER

CLIENT INCOME
- ☐ A. WEEKLY
- ☐ B. BI-WKLY
- ☐ C. MONTHLY
- ☐ D. ANNUAL
- ☐ E. 13 WEEKS

AMT:

SOURCES OF INCOME
- ☐ A. EMPLOYMENT
- ☐ B. UNEMPLOYMENT
- ☐ C. SOCIAL SECURITY

HH INCOME LEVEL
- ☐ D. AFDC/TANF
- ☐ E. DA
- ☐ F. SSI/SSD
- ☐ G. PENSIONS
- ☐ H. DISABILITY
- ☐ I. OTHER

FARMER
- ☐ A. FARMER
- ☐ B. MIGRANT
- ☐ C. SEASON

SITE:
HCCAO

HOUSEHOLD MEMBERS

SOC. SEC. NO.				
LAST NAME				
FIRST NAME				
DOB				
GENDER				
DISABLED				
ETHNICITY				
EDUCATION				
HEALTH INS				
VETERAN				
INCOME PERIOD				
SOURCE				
AMOUNT				

ID# _____
UNITS _____
DATE _____

INTAKE
NAME _____
DATE _____

DATA ENTRY
NAME _____
DATE _____

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

_____ _____ _____ _____

CLIENT SIGNATURE *DATE* *STAFF SIGNATURE* *DATE*

COUNTY - OUTCOME - OUTCOME DATE -

Early Head Start Prenatal Application
Permission and Policy Form

APPLICANT'S NAME:_____ BIRTHDATE:_____

. I give my permission to appear in photographs. ___yes ___no

. I give my permission for Early Head Start to obtain medical information from prenatal visits or any hospital where I have been a patient. ___yes ___no

. In case of Emergency 911 will be called and you will be transported by EMS to the nearest hospital.

_____
Initial

****

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.

. Grievance/ complaint is then to be submitted to the Program Manager who will in turn give it to the Early Head Start Director. If preferred the grievance/complaint may be submitted to the Head Start Director directly.

The Early Head Start Director shall have 10 days to resolve the grievance or will present it to the Policy Council for discussion.

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

_____**Signature** _____**Date**

_____ **Signature of parent or guardian (if minor)**

PRENATAL DENTAL EXAM RECORD

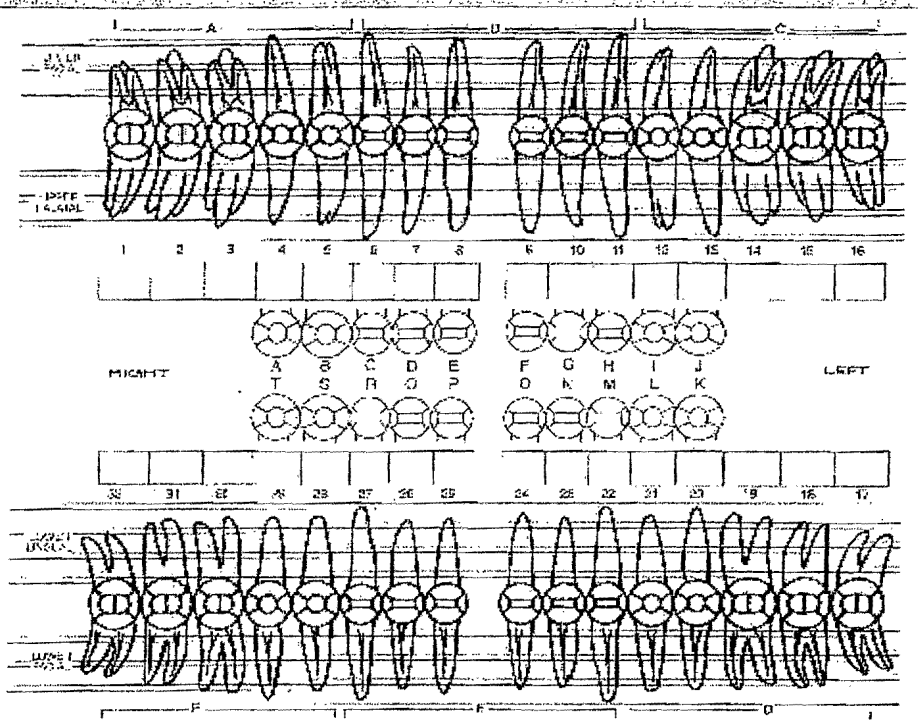
Patient's Name:_____ DOB:_____ Sex:_____

HS/EHS Center:_____ Insurance Provider:_____

HISTORY

ALLERGIES:

MEDICATIONS:



REMARKS

DATE	TOOTH	TREATMENT PLAN	EST.	DATE	TOOTH	SERVICES RENDERED	FEE

DENTAL PROVIDER

Please complete the following information for Head Start.

(Check "✓" All Boxes that Apply.)

SERVICES COMPLETED

- ☐ Oral Hygiene Instruction
- ☐ Topical Fluoride & Prophy
- ☐ Sealants Applied
- ☐ Systemic Fluoride Prescribed

EXAM & TREATMENT SERVICES

- ☐ Normal Exam, Healthy
- ☐ Treatment Indicated:
  - ☐ Treatment In Progress, _____No. of Appts. Needed
  - ☐ Referred to:
- ☐ All Treatment Completed
- ☐ Return to Clinic:

BILLING INFORMATION

- ☐ Patient t Paid Out of Pocket
- ☐ Private Insurance
- ☐ OHP/Medicaid ☐ IHS/Tribal
- ☐ Head Start Voucher

Dentist Signature:_____ Phone:_____ Exam Date:_____

1575 N. High St., Suite 100 • Hillsboro, OH 45133 Phone 937-393-4278 Ext. 242 • Fax 937-393

Highland County
FAMILY & CHILDREN FIRST COUNCIL
CONSENT FOR RELEASE OF INFORMATION

Name: _____ Date of Birth: _____

Social Security Number (optional): _____

Name: _____ Date of Birth: _____

Social Security Number (optional): _____

Name: _____ Date of Birth: _____

Social Security Number (optional): _____

Name: _____ Date of Birth: _____

Social Security Number (optional): _____

Name: _____ Date of Birth: _____

Social Security Number (optional): _____

The following agencies have my permission to exchange/give/receive/share/re-disclose information regarding service delivery planning for the purpose of securing, coordinating, and/or providing services for the above named person(s):

__X__ member agencies of the Early Childhood Collaborative Council (list attached)
__X__ member agencies of the "Cluster" Intervention Team (list attached)
__X__ specific agencies _____
__X__ Others _____

By signing this form, I authorize sharing of the following information if needed by the receiving agency to secure, coordinate, and provide services to the individual:

- **Identifying Information:** Name, birth date, sex, race, address, telephone number, social security number.
- **Case Information:** The above identifying information, plus medical (except for HIV or AIDS, unless initialed below), drug and alcohol treatment records, social history, treatment/service history, psychological evaluations, educational plans and assessments, and other personal information regarding me or the individual named above.
- **Financial Information:** Public assistance eligibility and payment information providing for establishing eligibility including but not limited to pay stubs, W2's and tax returns, and other financial information.
- **Employment/School Information:** Potential employment possibilities, employment and/or barriers to employment, work history as needed. When applicable, school/training enrollment, course work, tuition and fees, attendance, and grades.

AGENCY NAME	ECCC	IA	OTHE
Scioto-Paint Valley Mental Health Center	X	X	
Paint Valley Mental Health. Alcohol and Drug Addiction Board	X	X	
Hopewell Special Education Resource Center	X	X	
Highland County Children Services	X	X	
Highland County Juvenile Court	X	X	
Highland County Community Action Organization, Inc.	X	X	
Highland County MR/DD	X	X	
Greenfield Area Medical Center-*Member of Adena Health System*		X	
Family Recovery Services & BRIDGE Program	X	X	
Hillsboro City Schools	X	X	
Great Oaks & Turning Point Applied Learning Center	X	X	
Ohio Rehabilitation Services Commission (BVR)			X
H/C Department of Job & Family Services/Child Support Enforcement Agency	X	X	
Highland County Board Of Education	X	X	
Lynchburg-Clay Local Schools	X	X	
Greenfield-McClain Exempted Village Schools	X	X	
Bright Local Schools	X	X	
Fairfield Local Schools	X	X	
Highland County Head Start	X	X	
Highland District Hospital	X	X	
Highland County Domestic Violence Task Force		X	
Highland County Board of Health	X	X	
Highland County Society for Children and Adults, Inc.	X	X	
Ohio State University Extension Services—Highland County	X		
Family Information Network	X		
Southern State Community College/Success Center/ABLE			X
Samaritan Outreach Services			X
St. Vincent DePaul Society			X
Ministerial Society			X
Veterans Association			X
Mitchell Society			X
Adult Parole Authority			X
Community Corrections			X
Senior Citizens Center			X
Highland County Law Enforcement			X
Ohio Early Start			X
Green Thumb			X
Highland Metropolitan Housing Authority			X
Project STORK			X
Greenfield Outreach			X
Ohio Department of Job and Family Services (Employment Services)			X
Perspective Employers			X
School and Training Institutions _____			X
Family Stability Program			X
Highland County Educational Service Center			X
WEP Work Site(s) _____			X
Parent Representative	X	X	

Name: _____

Other: _____

_____

Yes NO _____ HIV and AIDS related diagnosis and treatment

I understand that the Consent for Release of Information expires 90 days from termination of case unless otherwise indicated herein by the consumer. I also understand that I may cancel this Consent for Release of Information at any time by stating so in writing with the date and my signature. The revocation does not include any information, which has been shared between the time that I gave permission to share information and the time that it was canceled.

This consent expires on the _____ day of _____, 20_____.

I understand that my signing or refusing to sign this consent will not affect public benefits or services for which I am eligible.

_____ _____
Signature of Person Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Witness/Agency Representative Date

Violation of federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

To all agencies receiving information disclosed as a result of this signed consent:

1. If the records released include information of any diagnosis or treatment of drug or alcohol abuse, the following statement applies:
   -Information disclosed pursuant to this consent has been disclosed to you from records whose confidentiality is protected by federal law.
   -Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.
2. If the records released include information of an HIV-related diagnosis or test results, the following statement applies:
   -This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written, and informed consent of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for the purpose of the release of HIV test results or diagnoses.
3. The information has been disclosed to you from records protected by federal and/or state confidentiality rules. Any further release of it is prohibited unless the person, to whom it pertains, DYS in the case of youth records, or applicable federal and/or state law, expressly permits the further disclosure.

HCCAO EARLY HEAD START HEALTH CHECKLIST PRENATAL/POSTPARTUM

NAME_____ ESTIMATED DATE OF DELIVERY_____

DATE OF BIRTH_____HEIGHT_____ DATE OF DELIVERY _____

START DATE_____WITHDRAW DATE_____ HOME VISITOR_____

INSURANCE_____ IF NONE, ODJFS REFERRAL DATE_____ COMPLETE INCOMPLETE

PREGNANT MOTHERS

DATE:

_____ Notify Health Services Manager of Prenatal Mother

_____Prenatal Assessment Form within 45 days (home visitor)

_____Prenatal Nutrition Assessment within 45 days WIC YES NO REFERRAL DATE_____ COMPLETE INCOMPLETE

_____Prenatal Depression Screening within 45 days REFERRAL YES NO DATE_____ COMPLETE INCOMPLETE

_____Dental Screening * DENTAL HOME_____ TX NEEDED: YES NO TX COMPLETED: YES NO

_____Benefits of Breastfeeding provided CLASS or CONSULTATION WANTED YES NO DATE_____

_____ PRENATAL VISIT SCHEDULE First Prenatal Visit (between 0 to 13 weeks): (home visitor) Medical Record for each visit

Visit Date	Initial	Weeks Pregnant	Weight	Additional Testing/Concerns	Next Visit Date

Visits should occur every 4 weeks for first 28 weeks:

Visit Date	Initial	Weeks Pregnant	Weight	Additional Testing/Concerns	Next Visit Date

Visits should occur every 2 weeks from 28 to 36 weeks:

Visit Date	Initial	Weeks Pregnant	Weight	Additional Testing/Concerns	Next Visit Date

Visits should occur every week until delivery from 36 weeks on:

Visit Date	Initial	Weeks Pregnant	Weight	Additional Testing	Next Visit Date

POSTPARTUM MOTHERS

DATE:

_____Notify Health Services Manager upon date of delivery

_____Postpartum Nutrition Assessment within 2 weeks WIC YES NO REFERRAL DATE_____ COMPLETE INCOMPLETE

_____Postpartum Depression Screening within 2 weeks REFERRED YES NO DATE_____ COMPLETE INCOMPLETE

_____Benefits of Breastfeeding Provided CONSULTATION: YES NO REFERRAL DATE_____ COMPLETE INCOMPLETE