Early Head Start Prenatal Application

The following information needs to be turned in, for your application to be complete.

- Application
- Prenatal Assessment
- Permission and Policy form
- HS/EHS Information Sheet
- Family Health History
- CSBG form
- Dental form
- Copy of your identification
- Copy of Insurance Card
- Proof of Pregnancy
- Proof of income
Early Head Start Prenatal Application

Name: ___________________________ Date of Birth __________________

Address: _____________________________________________________________

Street                  City/Town                     Zip                     County

Phone Number: ______________________________

Expected Due Date: ______________________________

Marital Status: __ Single, __ Married, __ Divorced, __ Separated, __ Living together

Does your family receive any of the following services?

________ Public Housing Assistance

________ Child Support/Alimony

________ Social Security (SSI, SSD, or SSA)

________ Energy Assistance

Race:

___ White

___ African American

___ American Indian

___ Native Hawaiian

___ Biracial/Multiracial

___ Other _______________________

Ethnicity: ____________ Non-Hispanic  ____________ Hispanic

I fully understand that the above information is correct to the best of my Knowledge.

_________________________________    ________________
Signature                                  Date
HCCAO Early Head Start Prenatal Assessment

Name: ___________________________ Date: ____________

What is your expected delivery date? ___________________________

When did you first receive prenatal care? ___________________________

When was your last visit? ____________, Next Visit? ____________

Who is your Care Provider? ___________________________

What is their phone number? ___________________________

Have you visited a Dentist in the last year? ____________

Are you having any dental problems at this time? ____________

Do you currently have any complications with your pregnancy? ____________________________________________, Previously? ___________________________

Do you have any chronic health problems? ___________________________

Do you have a medical card or other type of insurance? ___________________________

Are you enrolled in WIC? ___________________________

Have you been diagnosed with Anemia? ___________________________

Do you take Pre-natal vitamins? ___________________________

What medications are you taking? ___________________________

Do you use tobacco or drugs? ____________ Do you use Alcohol? ____________

Do you have a cat? ___________________________

Do you have any nutritional needs? ____________, If so what are they__________________________

How is your emotional well being at this time? ___________________________

Do you have any other questions or concerns? ___________________________

No referral needed ____________ Referral needed? ____________

Date of referral ____________ Date referral completed ____________
HCCAO Early Head Start Prenatal Application

Permission and Policy Form

Applicants Name: __________________________ Date of Birth: ____________

I give my permission to appear in photographs. ______ yes ______ no

I give my permission for HCCAO Early Head Start to obtain my medical and dental
information from doctors, dentists or hospitals where I have been a patient. Also, to obtain
information from Job & Family Services for verification of cash assistance, food assistance
and child support benefits.

____ yes ______ no

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

__________ Initials

Grievance Procedure

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 should then be submitted to the Director of the Early
Childhood Programs. The Director shall have 10 days to resolve the grievance /
complaint or present it to the Policy Council for discussion.

I have read and understand the grievance procedure.

_________________________________________ _______________________
Signature Date

_________________________________________
Signature of parent /guardian (if applicant is a
minor.)
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 Paper? ______ 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 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 ____________


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: ____________________________
Family Health History

Child's Name ___________________  DOB: ___________  Gender: ___
Parent / Guardian Names: ____________________________________________

Family History

1. Have any of the child's direct blood relatives (parents, grandparents, aunts, uncles, brothers and sisters) had any of the following conditions? ___ yes ___ no

If yes, please check the condition(s)

___ Bleeding Conditions  ___ Allergies  ___ Anemia  ___ Asthma

___ High Blood Pressure  ___ Cancer  ___ Diabetes  ___ Seizures

___ Heart Problems  ___ Mental Illness  ___ Mental Retardation

___ Overweight  ___ Tuberculosis  ___ Sickle Cell  ___ SIDS

___ Sickle Cell Trait  Other: _______________________________________

Child's Medical Record

1. In the last year, has this child had any of the following Conditions? __ Yes __ No

___ Allergies  ___ Anemia  ___ Asthma  ___ Boils  ___ Bleeding Conditions  ___ Cancer

___ Liver Disease  ___ Broken Bones  ___ Chicken Pox  ___ Diabetes

___ Eczema ___ Hives  ___ Heart Conditions  ___ High Blood Pressure  ___ Mumps

___ High Lead  ___ Measles  ___ Immune System Disease  ___ Inherited Disease

___ Seizures  ___ Mental Retardation  ___ Mental Illness  ___ Overweight

___ Pneumonia  ___ Sickle Cell Disease  ___ Sickle Cell Trait  ___ Tubes in ears

___ Tonsils Removed  ___ Rheumatic Fever  ___ Scarlet Fever  ___ Other: ______

2. Is your child receiving treatments for the following conditions? ___ Yes ___ No

___ Anemia  ___ Asthma  ___ Overweight  ___ Hearing Difficulties  ___ Diabetes

___ Vision Problems  ___ High Lead Levels  ___ Other ____________________________________

3. Is your child currently taking any medication at home? ___ Yes ___ No

Name of Medication:

Dose: __________________________________  How Often: _______________________

4. If your child has a health problem, has it been diagnosed by a doctor or health care professional: ___ Yes ___ No, If yes explain:
Family Health History

5. Has your child ever had seizures? _____Yes _____No
   If yes explain:

6. Has your child ever been diagnosed with Asthma? _____Yes _____No
   If yes explain:

   Have they ever been hospitalized for Asthma?

7. Has your child ever had an allergic reaction? _____Yes _____No
   If yes explain to what and what type of reaction your child had.

8. Has your child ever had problems with the following? _____Yes _____No
   _____Frequent ear infections  _____Frequent sore throats  _____Frequent Fevers
   _____Frequent Coughs  _____Frequent Bed Wetting  _____Frequent Chest Pains
   _____Frequent Colds  _____Frequent Stomach Aches  _____Problems with Urine
   _____Problem with Bowels  _____Problems Eating  _____Problems with Teeth
   _____Problems Hearing  _____Problems Seeing  _____Eye Problems
   _____Speech Problems  _____Frequent Trouble Sleeping  _____Temper Tantrums
   _____Other Problems: ____________________________________________

9. Has your child ever been involved in a child abuse or neglect incident or case
   _____Yes _____No   If yes, explain:

10. Does your child have any additional conditions that interfere with his/her daily
    activities? _____Yes _____No

Behavioral / Activity History

1. Does your child currently have an IEP? _____Yes _____No   If so, what school
district completed the IEP?
Family Health History

Complete the following Chart:

<table>
<thead>
<tr>
<th>Action or Activity</th>
<th>At what age did your child do the Following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sit up without help</td>
<td></td>
</tr>
<tr>
<td>Crawl</td>
<td></td>
</tr>
<tr>
<td>Walk</td>
<td></td>
</tr>
<tr>
<td>Talk</td>
<td></td>
</tr>
<tr>
<td>Feed and Dress Self</td>
<td></td>
</tr>
<tr>
<td>Use the Toilet</td>
<td></td>
</tr>
<tr>
<td>Understand things being said to them</td>
<td></td>
</tr>
<tr>
<td>Follow simple Directions</td>
<td></td>
</tr>
<tr>
<td>Play with toys</td>
<td></td>
</tr>
<tr>
<td>Use Crayons</td>
<td></td>
</tr>
</tbody>
</table>

Medical Dental Home

1. Do you have a regular Doctor for your child? _____ Yes _____ No

Name of Doctor:

Address:

Phone Number:

When did you obtain a doctor for your child? Before or After Enrollment? (Circle One)

2. Do you have a regular Dentist for your child? _____ Yes _____ No

Name of Dentist:

Address:

Phone Number:

3. When did you obtain a dentist for your child? Before or After Enrollment/ (Circle One)

4. Does your child need dental treatment? _____ Yes _____ No

   If yes, has the appointment been made or is it complete?

Parent / Guardian Signature that completed survey: ________________________________

Date Completed: ________________________________
Client ID #: ____________________________  Program Year: ____________________________

CSBG INTAKE FORM

SS #: ____________________________  Last Name: ____________________________  First Name: ____________________________

DOB: ____________________________  Address: ____________________________  County: ____________________________

City: ____________________________  Zip: ____________________________  Whose Phone: ____________________________

Phone #: ____________________________  Message Phone #: ____________________________

Gender: □ Female  □ Male  Disabled: □ Yes  □ No  Ethnicity: □ Black or African American  □ Native Hawaiian/Pacific Islander  □ Native American/Native Alaskan  □ Other  □ Hispanic or Latin  □ Multi-Race (any 2 or more above)  □ White  □ Asian

Agency Site: Highland County Community Action

Education:
□ A. 0-8  □ B. 9-12 (Non-Grad)  □ C. HS Grad/GED  □ D. 12+
□ E. 2-4 yr. Grad College

Food Stamps: □ Yes  □ No
Health Insurance:
□ A. Medicaid  □ B. Medicare  □ C. Private  □ D. Self-Ins.
□ E. None  □ F. Unknown

Farmer:
□ A. Farmer  □ B. Migrant  □ C. Seasonal

Veteran: □ Yes  □ No

Family Type:
□ F. Single Par/Female  □ M. Single Par/Male  □ Two Parent
□ Single  □ Couple  □ Other

Housing:
□ Own  □ Homeless  □ Rent  □ Other

Length of time in home: □ Years  □ Months

Income Eligibility Period:
□ A. Weekly  □ B. Bi-Weekly  □ C. Monthly  □ D. Annually
□ E. 13 Weeks  □ F. 3 Months

Income Level:

Income Amount: $

Source of Income:
□ A. Employment  □ B. Unemployment  □ C. Social Security  □ D. TANF
□ E. GA  □ F. SSI/SSD  □ G. Pension  □ H. No Income  □ I. Other  □ J. Zero Income
□ K. Refused – Only use for programs that do NOT require income verification

Other Household Members
Use codes from above ONLY for information listed below


Code #: ____________________________  Intake: ____________________________  Initials: ____________________________  Date: ____________________________

# of Units: ____________________________  Date of Service: ____________________________  Data Entry: ____________________________

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: ____________________________

Outcome: Level 1 - ____________________________  # ____________________________  Level 2 - ____________________________  # ____________________________
### 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
- [ ] X-Rays
- [ ] Fluoride application
- [ ] Other

#### Examination and Treatment Record:

**Indicate Teeth Needing Treatment (below on chart):**

<table>
<thead>
<tr>
<th>Tooth # or Letter</th>
<th>Description of Dental Services Required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Date of Exam:

**Upper Teeth:**

- Central Incisor: 8-7 yrs.
- Lateral Incisor: 7-8 yrs.
- Canine (Cuspid): 10-12 yrs.
- First Molar: 9-11 yrs.
- Second Molar: 10-12 yrs.

**Lower Teeth:**

- 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

<table>
<thead>
<tr>
<th>Dental Treatments</th>
<th>Date</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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