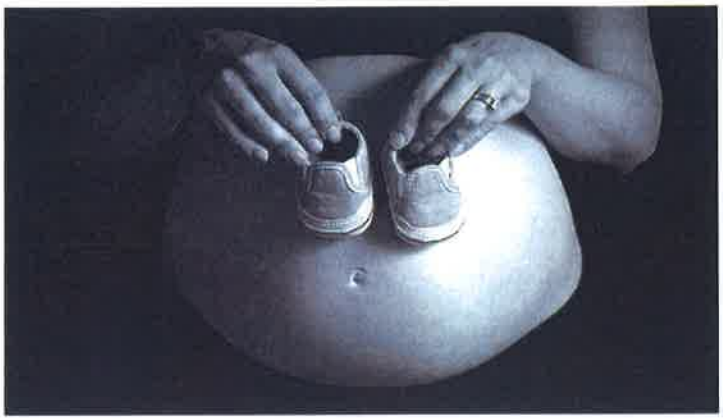
Early Head Start Prenatal Application



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.)

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 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? ___ 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: _____

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 interferes 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:

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

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:** _____
City: _____ **Zip:** _____ **County:** _____
Phone #: _____ **Message Phone #:** _____ **Whose 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

Client E-mail:

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 ☐ D. Self-Ins.
☐ B. Medicare ☐ E. None
☐ C. Private ☐ F. Unknown

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

Veteran:
☐ Yes
☐ No

 # In HH:

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 ☐ D. Annually
☐ B. Bi-Weekly ☐ E. 13 Weeks
☐ C. Monthly ☐ F. 3 Months
☐ G. 6 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

SS#					
Last Name					
First Name					
DOB					
Gender (M/F)					
Disabled (Y/N)					
Ethnicity (B, A, NHPI, NA, HL, W, O,MR)					
Education (A, B, C, D, E)					
Veteran (Y, N)					
Health Insurance (A, B, C, D, E, F)					
Income Period (A, B, C, D, E, F)					
Source (A, B, C, D, E, F, G, H, I, J, K)					
Income Amount					
Relationship to Applicant					

													Initials	Date
Code #:														
# of Units:												**Intake:**		
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): _____

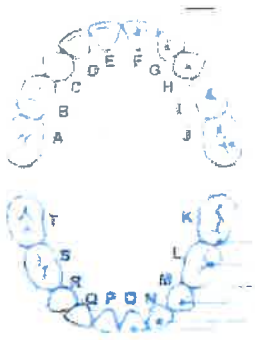
1) Diagnostic and Preventive Procedures Performed:
- ❑ Clinical Examinations
- ❑ Prophylaxis
- ❑ X-Rays
- ❑ Fluoride application
- ❑ Other _____

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