

# CARD Head Start/Early Head Start Application Checklist

Child Name:	Ì
Center Name:	

## APPLICATION CHECKLIST

Complete applications to CARD's Head Start/Early Head Start will include the following items. Make sure you've included all necessary items before turning in your child's application. After the application is complete, call and make an appointment with your FSR for the application to be accepted. <a href="Incomplete">Incomplete</a> applications will not be accepted.

	Family Application (3 pages)
	Income Worksheet (1 page)
	Proof of Income
	Agency Expectations for Early Childhood Program
	Agreement for Services(3 pages)
	Proof of Pregnancy
For	each child applying:
	Child Application (2 pages)
	Birth Certificate
	Social Security #'s for all family members
	Child's Health Insurance Information
	Current Well Child Checkup and Dental
	Proof Of Current Immunizations
	Documentation for Diagnosis or IEP/IFSP
	Documentation for Food Allergies/Health Notes

\*You must provide a proof of receipt for any public benefit programs you receive assistance from.

\*If you are a foster parent, you must provide a copy of the foster care placement papers for each foster child who is applying.

\*If you indicated that your child was disabled or required special assistance, you must provide a copy of the IEP/IFSP. If there is no IEP/IFSP, you must provide a copy of the medical record with the diagnosis along with formal evaluation(s) completed by primary care physician or medical provider.

\*If there are custody issues regarding your child, you must provide a copy of the legal custody papers.

Verify that all of your completed, signed application forms and copies of your supporting documentation are all together in one application folder. If so, you're ready to have your application reviewed.

Return your application to your local Head Start/Early Head Start site.

How to provide proof of income
Make a copy of the first page of your current tax
return (tax form 1040) that shows your family's
annual gross income for the current tax
year. Other proofs of income can be your three
most recent pay stubs, your SSI or TANF
award letter, or some other official
documentation of income whether from your
employer, an insurance company, or the
oovernment.

How to get your child's birth certificate If your child was born in Oklahoma, you can get a copy of your child's birth certificate at the Tulsa Health Department at 315 South Utica, Monday – Friday, 8:30 a.m. – 4:00 p.m. Call 594-4840 if you have questions. If your child was born in another state, contact that state's Department of Vital Records for a copy of your child's birth certificate.

# How to get a well-child checkup for your child

Your child's health is very important. Every child should have a well-child checkup, which is a checkup provided by a doctor to assess your child's growth and development. You can get free or reduced-fee well-child checkups by visiting the Health Department, the Morton Clinic, or the OSU Health Care Center. A lead screening test will also be required for enrollment. If your child is three-years-old or older, a dental exam is required; otherwise, your child will need a dental screening completed by your child's doctor at his or her well-child check up. For more information on well-child checkups go to http://www.okhca.org/publications/pdflib/SGUE NG%E2%80%93EPSDTG.pdf Be sure to ask your child's doctor for a copy of the well-child checkup so that you can include it with your child's application.

# How to get a copy of your child's current immunization record

Your doctor or clinic can provide a copy of your child's current immunization record. If you do not have a doctor, we can connect you with a medical provider.

# How to provide documentation of your child's health insurance

Bring a copy of your Medicaid, SoonerCare, private insurance card or other proof of insurance. If your child doesn't have health insurance, we can help you complete a SoonerCare application for your child.

### How to provide proof of receipt of SSI, TANF, or OKDHS Child Care Assistance

Bring a copy of your benefit award or Notice of Action letter. If you cannot find this letter, contact your local OKDHS office to ask for verification assistance. If you need assistance finding your local OKDHS office, call 211 or 877-836-2111.



CARD Head Start / Early Head Start
CHILD APPLICATION FORM
You should complete only one Family Application Form for your family.
Please complete one Child application for each child applying.

Child N	lame;		

Forever the management of the control of the contro	ormation
Middle Hanning with a first that the control of the state	Date of Birth: SS#:
Child's Name:	Gender: ☐ Male ☐ Female
Child's Preferred Name:	Hispanic:
Race (check all that apply)	☐ Yes
☐ Asian ☐ Native American ☐ White ☐ Black	□ No
☐ Pacific Islander ☐ Other:	Speaks English? ☐ Very Good ☐ Good ☐ Not Good
Primary Language:	□ Not At All
Nationality:	Is your child a returning student: ☐ Yes ☐ No
This child lives with: ☐ One Parent ☐ Two Parents ☐ Guardia	ın □ Shared Custody □ Foster Parent
Do you have custody of the child listed above? \( \square\) Yes \( \square\) No	☐ Shared
If no, give the legal name of the person who has legal custody:	
If shared custody, with whom do you share custody (name):	The second se
Branch Control of the	bility
Program Term Agency	Site Participation Year
HS or EHS	
Application Status Application Date	Income Status Number in Family
T portos and the same and the s	
CONTROL OF THE CONTRO	<b>IS</b>
Program Preference:	
Contor Board Education Program (at a school site)	
☐ Home-Based Education program (and solider stee) ☐ Home-Based Education program (only available in selected area	s; your child must be younger than 36 months)
Site Preference:	and the second s
Child Care	nformation
Is the child named above currently enrolled in a full-time childcare or	education program? ☐ Yes ☐ No
If yes, what type?   Childcare Center   Family Childcare Home	☐ Relative's Home ☐ Home ☐ Pre-School
Officer:	
Are you looking for a childcare or education program so that you car	n attend school or work? ☐ Yes ☐ No
	7   1 VAC     NIA
	eama enge and principal call hold for all, to vive plus Extended and the
Please Note: Some CARD sites provide services from 6:00-6:30 a.m. to 1:00-1:30 p.m., as either private pay arrangement or eligible families may apply OKDHS childcare assis	dance subsidies towards the Control of the Property of the Control
Do you have concerns about your child's overall health and develop	HIGHRY IN 169 IN 140
If yes, describe concerns:	
Who has expressed concerns:	D/Early Childhood Staff
in thinking out of the outer in the control of the control outer in the	(specify)
☐ Sooner Start ☐ Family Member ☐ Other	r pood assistive services? $\square$ Yes $\square$ No
Does your child have a documented disability, a certified IEP/IFSP o	LIBERT OSSISTAG SCLANOOS: TO 100 TO 110
If yes, what is the date of the IEP/IFSP:  (If yes, you must provide a copy of the IEP/IFSP. If there is no IEP/IFSP, you must provide a copy of the IEP/IFSP. If there is no IEP/IFSP, you must provide a copy of the IEP/IFSP.	copy of the medical record with the diagnosis along with the formal evaluations(s) completed
by your child's primary care physician or medical provider.	
by your child's primary care physician or medical provider.)  Do you have any concerns about your child's mood or behavior? (Fo	or example: excessive crying, aggressive behavior, tantrums, or
sexual behavior.) ☐ Yes ☐ No	
If yes, describe concerns:	



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Child N	àme:	

Please complete the following two questions only of your child is 0-12 months old.  What does your child eat?	Nutritional Information	
What does your child eat?   Breast Milk   Milk   Formula: (Specify brand)	Please complete the following two questions only of your child is 0-12 months old.	
Prysician/Clinic:	What does your child eat? ☐ Breast Milk ☐ Milk ☐ Formula: (Specify brand) _	
Physician/Clinic:		
Physician/Clinic:	Feeding Method: ☐ Breast Fed ☐ Bottle Fed	orregion para composition de la calcimentación de la composition de la calcimentación de la calcimentación de l
Physician/Clinic:	Medical Home Information	
Specialist:	Physician/Clinic:	Pilone:
SoonerCare   Medicaid   Indian   Private   None   Other:		
Insurance Provider's Name:	Specialist:	Phone:
Insurance Policy Number or ID:	Type of Health Insurance: ☐ SoonerCare ☐ Medicaid ☐ Indian ☐ Private ☐	Pontal Coverage Included: T Ves T No.
Insurance Policy Number or ID:	Insurance Provider's Name:	Dental Coverage Included, Lines Lines
Does your child receive regular medical care:	Incurance Policy Number of II )	Insurance Expiration Data.
Does your child receive regular dental care?   Yes   No   When was your child's last dental screening?   Medical, History   More than 2 weeks overdue   Medical, History   More than 2 weeks overdue   More t	Does your child receive care through Indian health Services? Li Yes Li No	last wall shild ovem?
Has your child ever been hospitalized or had surgery?	Does your child receive regular medical care: Li Yes Li No When was your child's	last dental sergening?
Has your child ever been hospitalized or had surgery?	Does your child receive regular dental care? U Yes LINO When was your child s	s last demai screening r
Has your child ever had a serious accident?	Nedical History,	有效在1000年的1967年的1968年的1968年的1968年的1968年的1968年的1968年的1968年的1968年的1968年的1968年的1968年的
Identify any past or present health conditions your child has had:	Has your child ever been hospitalized or had surgery? Li Yes Li No Ir yes, explain	
□ Anemia □ Diabetes □ Asthma □ High lead Level □ Hearing difficulties □ Seizures □ Trouble Chewing or Swallowing □ Traumatic Brain Injury □ Wears hearing aid □ Sickle Cell Disease □ Frequent Constipation □ Cancer □ Vision Problems □ Allergies □ Frequent Diarrhea □ Overweight □ Glasses are prescribed □ Eczema □ Heart Murmur/Condition □ Speech Concerns □ Other:	Has your child ever had a serious accident? Li Yes Li No If yes, explain:	
□ Hearing difficulties □ Seizures □ Trouble Chewing or Swallowing □ Traumatic Brain Injury □ Wears hearing aid □ Sickle Cell Disease □ Frequent Constipation □ Cancer □ Vision Problems □ Allergies □ Frequent Diarrhea □ Overweight □ Glasses are prescribed □ Eczema □ Heart Murmur/Condition □ Speech Concerns □ Other: □ Other: □ Other: □ Other: □ No Will your child take medications at school? □ Yes □ No (If yes, provide a copy of the medication prescription.) If yes, what is the name of the medication: □ No (If yes, provide a copy of the medication prescription.)    Birth History □ Sirth History □ More than 2 weeks overdue		Mulah lood Laval
□ Glasses are prescribed □ Eczema □ Heart Murmur/Condition □ Speech Conterns □ Other: □ Othe	☐ Anemia ☐ Diabetes ☐ Astrima	
□ Glasses are prescribed □ Eczema □ Heart Murmur/Condition □ Speech Conterns □ Other: □ Othe	Thearing difficulties  LISeizures  LISeizures  LISeizures  LISeizures  LISeizures  LISeizures	• • •
□ Glasses are prescribed □ Eczema □ Heart Murmur/Condition □ Speech Conterns □ Other: □ Othe	Wears hearing aid LISICKIe Cell Disease LI Frequent Consulpation	
Does your child take medications at home? ☐ Yes ☐ No Will your child need to take medications at school? ☐ Yes ☐ No (If yes, provide a copy of the medication prescription.)  If yes, what is the name of the medication:  Why does your child take the medication:  Birth History  Birth History  Birth History  Delivery   Ocation: ☐ Hospital/Clinic ☐ Birthing Center ☐ Home ☐ Unknown	□Vision Problems □ Allergies □ Frequent Diatrilea	•
Does your child take medications at home? ☐ Yes ☐ No  Will your child need to take medications at school? ☐ Yes ☐ No (If yes, provide a copy of the medication prescription.)  If yes, what is the name of the medication:  Why does your child take the medication:  Birth History  Birth History  Birth History  Gestational Age: ☐ Pounds ☐ Ounces Length: ☐ Inches  Gestational Age: ☐ Term ☐ Premature (weeks) ☐ More than 2 weeks overdue  Type of delivery: ☐ Vaginal ☐ Cesarean ☐ Unknown  Length of infant's hospital stay: ☐ Routine ☐ Non-Routine, Length of Stay:  Delivery   ceation: ☐ Hospital/Clinic ☐ Birthing Center ☐ Home ☐ Unknown	□Glasses are prescribed □ Eczema □ Heart Wurmur/Condition	
Will your child need to take medications at school?	- Interior Bull House O. F. Mar. F. Ma	D Other.
f yes, what is the name of the medication:  Why does your child take the medication:  Birth History  Birth His	Does your child take medications at nome? Lifes Lino	of the medication prescription \
Why does your child take the medication:    Birth History	Will your child need to take medications at school? Lifes Lino (tryes, provide a copy)	of the medication prescription.
Birth History  Birth Weight: Pounds Ounces Length:inches  Gestational Age: ☐ Term ☐ Premature (weeks) ☐ More than 2 weeks overdue  Type of delivery: ☐ Vaginal ☐ Cesarean ☐ Unknown  Length of infant's hospital stay: ☐ Routine ☐ Non-Routine, Length of Stay:  Delivery Location: ☐ Hospital/Clinic ☐ Birthing Center ☐ Home ☐ Unknown	If yes, what is the name of the medication:	
Birth Weight: Pounds Ounces Length: Inches  Gestational Age: ☐ Term ☐ Premature (weeks) ☐ More than 2 weeks overdue  Type of delivery: ☐ Vaginal ☐ Cesarean ☐ Unknown  Length of infant's hospital stay: ☐ Routine ☐ Non-Routine, Length of Stay:	Why does your child take the medication:	
Gestational Age: ☐ Term ☐ Premature (weeks) ☐ More than 2 weeks overdue  Type of delivery: ☐ Vaginal ☐ Cesarean ☐ Unknown  Length of infant's hospital stay: ☐ Routine ☐ Non-Routine, Length of Stay:	Ditti nistory	#KTNAmon and all all all all all and the first manager of relative to be presented as a contraction of the present of the pres
Type of delivery: □ Vaginal □ Cesarean □ Unknown  Length of infant's hospital stay: □ Routine □ Non-Routine, Length of Stay:  Delivery Location: □ Hospital/Clinic □ Birthing Center □ Home □ Unknown	Birth Weight: Pounds Utinces Length. Mary than 2 weeks	overdue
Length of infant's hospital stay:  Routine  Non-Routine, Length of Stay:  Length of Infant's hospital/Clinic  Routine  Non-Routine, Length of Stay:  Length of Infant's hospital/Clinic  Routine  Non-Routine, Length of Stay:  Length of Infant's hospital  Non-Routine, Length of Infant's hospital  Non-Routine, Length of Infant's Length o	Gestational Age: LI Term LI Premature (weeks) LI More than 2 weeks	Dyeitue
Delivery Location: 🖂 Hospital/Clinic 💢 Birthing Center 🔛 Home 🔛 Unknown	Type of delivery: Li Vaginal Li Cesarean Li Unknown	
Delivery Location: LI Hospital/Clinic Li Birthing Center Li Home Li Onknown	Length of infant's nospital stay:   Routine   Non-Routine, Length of Clay	N/O
the state of the second state of the delivery (are term fotal distress atc)? \( \Pi \) \( \text{Ves} \) \( \Pi \) \( \text{Inknown} \)	Delivery Location: Li Hospital/Clinic Li Birthing Center Li Home Li Chikico	MI ∧N2 □ Ves □ No □ Unknown
Were there any complications associated with this delivery (pre-term, fetal distress, etc)? ☐ Yes ☐ No ☐ Unknown		oj: 11 100 11 110 11 onimo
f yes, describe:	If yes, describe:	
Jid papy nave any problems at birth? Lill fes Lill No. II yes, describe.	Did papy nave any problems at Diffir Lighters Light 190 in yes, describe.	
Jescripe observable birth defects	Describe observable birth defects:	
	Did mother have any health problems during pregnancy or delivery? ☐ Yes ☐ No	



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# Primary Adult:	
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	Contact In	formation				
Home Address:	HANGE AM FEARING CONTRACTOR OF THE FRENCH	Apartment Complex Name:				
City:	State:	Zíp:	County:			
Mailing Address: (If different	than the address given above)					
Phone Number	Type of Phone	Is this your Notes & Comments primary phone (specify if this is a message phone)				
	☐ Home ☐ Work ☐ Cell ☐ Other	☐ Yes ☐ No				
	☐ Home ☐ Work ☐ Cell ☐ Other	☐ Yes ☐ No	,			
	☐ Home ☐ Work ☐ Cell ☐ Other	☐ Yes ☐ No				
	☐ Home ☐ Work ☐ Cell ☐ Other	□ Yes □ No	The state of the s			
	Family In	formation				
Which of the following best d	lescribes your type of family: ☐ One Pa	nrent-Female □ One	Parent-Male 🛘 Two Parents			
Haw many naonla in your im	mediate family live with you? , children and other dependents who liv					
How many people do you live with at your current address?						
Do any of the following description ☐ A parent is incarcera	ribe your family, please check all that ar ted  □ Grandparent or Relative other th	oply:	VI.III.9 0			
Type of Housing: ☐ House	☐ Apartment ☐ Mobile Home/Trailer	☐ Homeless Shelter I	Other:			
House Payment Type: ☐ O	wn □ Rent □ Subsidized Housing □	I Living with family mem	nber/friend			
Are you or your child homele	ss, living in a shelter, pay a weekly rate	for your housing, await	ing foster care placement, or living in a car? ☐ Yes ☐ No			
Are you or your child living a	t a friend or relative's house because yo	ou cannot afford or find	affordable housing? ☐ Yes ☐ No			
What is the primary language	Are you or your child living at a friend or relative's house because you cannot afford or find affordable housing? ☐ Yes ☐ No What is the primary language spoken by your family at home: How many times have you moved in the past 12 months?					
What is your family's primary means of transportation: ☐ Own a car ☐ Bus/Public Transportation ☐ Friend/Relative ☐ Taxi ☐ Other: ☐ Material left at home ☐ Radio						
How did you find out about CARD's Head Start/Early Head Start? ☐ News Paper ☐ Flyer ☐ Material left at notife ☐ Nadis ☐ Sibling previously enrolled at CARD ☐ Social Service Agency, if so which: ☐ Walk In ☐ Public School, if so which: ☐ Sign at CARD site ☐ CAPTAIN:						
Which of the following progra	Which of the following programs would you be interested in: □ Vo-Tech □ Community College □ Housing □ Weatherization					
Are you a CARD employee? ☐ Yes ☐ No						



# CARD Head Start / Early Head Start FAMILY APPLICATION FORM

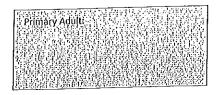
You should complete only one Family Application Form for your family.
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Primary Adul		Marin
<b>企业的多位</b>	医别类的口息	機關的關係

Adult 1		/eteranici	rcle Yes or No.				
Legal Name	12 de la 12 de	Date of Birth	Relation to Child Applying  Parent Grandparent Uncle/Aunt Foster Parent Other:	Race (check all that apply)  Cl Asian  Native American  White Black Pacific Islander  Other;	Hispanic □ Yes □ No	Highest Grade Completed  11 or Less  High School Graduate  GED  Two Year Degree  Bachelors  Masters or Higher	Employment Status  Part Time  Full Time  Unemployed  Student/Training  Disability  Other:
Social Security Number	,		•				Place of Employment/School
							Nationality/Place of Birth
Email Address	☐ Lives		Custody □ Yes □ No □ Shared	Gender □ Female □ Male	Primary Language	Speaks English?  ☐ Very Good ☐ Good ☐ Not Good ☐ Not at All	Nationality/Place of Gitti
Adult 2		eteran cii	cle Yes or No				
Legal Name	in the state of th	ate of Birth	Relation to Child Applying I Parent II Grandparent II Uncle/Aunt	Race (check all that apply)  ☐ Aslan  ☐ Native American  ☐ White  ☐ Black  ☐ Pacific Islander  ☐ Other:	□ No	☐ 11 or Less ☐ High School Graduate ☐ GED ☐ Two Year Degree ☐ Bachelors ☐ Masters or Higher	Emptoyment Status  Part Time Full Time Unemployed Student/Training Other:
Social Security Number	,						Place of Employment/School
Email Address	☐ Lives v ☐ Provid Support ☐ Teen F ☐ Pregna	vith Family es Financial Parent ant	□ Yes □ No □ Shared	□ Female □ Male	,	Speaks English? ☐ Very Good ☐ Good ☐ Not Good ☐ Not at All	Nationality/Place of Birth
nie v Examema	hore /	Edde de la Carre	children or denenden	s in vour immediate	family who are not	applying to CARD Head St	art/Early Head Start)
Vame Vame	ilitera (L		Date of Bill	h SS#	Race		spanic □ Yes □ No spanic □ Yes □ No
1	<u> </u>		orF			Hi	spanic □ Yes □ No
3		M	or F				spanic □ Yes □ No spanic □ Yes □ No
4	3 15 EUR H75 (	M c	or F				
amily income			f the fello			<u> </u>	Beding 14 (1994) 2 Angun 2011.
			ng any of the follow	WIC	Unemployment	Child Support	Support from
「ANF □ Yes □ No □Formerly	lncome (S □ Yes □	SI)	Subsidy	□ Yes □ No	☐ Yes ☐ No		Friends/Famly □ Yes □ No
Food Stamps yes	<u></u>	circle answe				Christiagas Peal, Withinstill and P.	(258 5-53 5056) 1887 A 884 F
	ender va. Dankan	<b>公共</b>				物化排作的關係是	<b>福林县766-1884</b>



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Name   Relationship to Child   Your Child(ren) can be released to this person   Yes   No	173.100 173.100	Emergency	y Contacts Other Than	Persons L	isted on	Page 2	
Address    City   State   Zip		######################################	T	Your Ch	ild(ren) c	an be released to this p	erson □ Yes □ No
Address    Phone 1				Emergen	cy Conta	ıct? □ Yes □ No	
Phone 2	tact	Address		City		State	Zip
Address   City   State   Zip      Fhone 1	Con	□ Cell □ Home	☐ Cell ☐ Home			□ Cell □ Home □ Work	
Address City State Zip    Phone 1		Name	Relationship to Child		☐You	ır Child(ren) can be rele	ased to this person
Address    Phone 2					Except	ions:	
Phone 1	tact 2	Address		City		State	Zip
Emergency Contact? ☐ Yes ☐ No  Address  City  State  Zip    Phone 1	Com	☐ Cell ☐ Home	□ Cell □ Home			□ Cell □ Home □ Work	
Address    Phone 1		Name	Relationship to Child				rson □ Yes □ No
Phone 1	itact 3	Address		City		State	Zip
I certify that the information provided in this application is true and correct to the best of my knowledge. I understand that the information about my income may be reviewed by representatives of the State of Oklahoma, the Federal Government, independent	1000	☐ Cell ☐ Home	☐ Cell ☐ Home ☐ Work	Varues me a		☐ Cell ☐ Home ☐ Work	
information about my income may be reviewed by representatives of the state of Oktahorna, the Federal Government, many		Gertific	ation of Information Pr	ovided in A	t of my k	nowledge Lunderstan	I that the
auditors, or others as necessary for the authinistration of this program.	infor	I certify that the information provided in this application is true and correct to the best of my knowledge. I distribute the state of the best of my knowledge. I distribute the state of the state of the state of Oklahoma, the Federal Government, independent auditors, or others as necessary for the administration of this program.					
Parent or Guardian's Signature: Date:						Oate:	
Print Parent or Guardian Name:	Print						
FSR Signature: Date:	FSR	Signature:		<u> </u>		)ate:	