owcap
Ogden-Weber Community Action Partnership

Dear Parent/Guardian:

OWCAP Head Start/Early Head Start is a School Readiness Program that is **free** for children and families accepted into these programs.

- **Early Head Start/Prenatal Program-** is to support pregnant women and expectant fathers. Prenatal Care and Education offered. Learn how to fully care for your newborn as well as yourself.
- **Early Head Start** is for children under the age of 3. OWCAP offers a home based and a center based program.
- **Head Start** is for children ages 3 & 4.

Children with disabilities or special needs are encouraged to apply.

We do not provide transportation to students; however, we can provide transportation support.

Refer to our website or call for registration dates and appointments.

When you come to registration. Please have the following items with you, if possible:	
☐ Birth Certificate	☐ Proof of Address (utility bill, picture ID, ect.)
☐ Immunization Record	☐ Insurance Card (Private, Medicaid. CHIP, ect.)
☐ Proof of Income for the past 12 months **One of the following** • Last year's w-2 form • Tax form 1040's • Current financial assistance printout from DWS • Social Security Letter (reflecting amount of income) • Employer letter • Check stubs • Proof of Foster Placement or State Custody Letter from DCFS	
Other items needed, if your child is enrolled: ☐ Physical Exam (to include Blood Pressure, Hemoglobin, Lead Test) ☐ Dental Exam (to include cleaning, fluoride, treatments)	

Frequently Asked Questions:
Does my child have to be potty trained to attend Head Start? • No, our teachers are trained to work with children and the parent to help with potty training.
Is there an attendance requirement for my child to attend Head Start/Early Head Start? • Regular attendance creates a lifelong habit that impacts your child's success in school. We want your child taking advantage of every opportunity to be a part of Head Start. An 85% attendance rate must be maintained, so you do not want your child to miss more than 1 day per month.
What is the Home-Based Program? • The Home-Based Program has a home visitor that comes to the home each week to work with the parents and the child on school readiness, parenting, health, and other goals. They also have a socialization twice a month to meet other children and families.

801-399-9281 [ph]
801-399-9887 [fx]
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info@owcap.org
3159 Grant Ave
Ogden, UT 84401

❑HS
❑EHS

OWCAP Head Start/Early Head Start Application
Family Member Information

owcap

Child Applying for Head Start/Early Head Start

First	Middle	Last	Preferred

Birthday	Gender	Race (*check all that apply*)	Ethnicity	Primary Language / Other Languages
		☐ Asian ☐ White ☐ Pacific Islander ☐ Black ☐ Native American ☐ Other _____	☐ Hispanic ☐ Non-Hispanic	Primary Language _____ Other Languages _____

Medical Insurance: ☐ Medicaid ☐ CHIP ☐ Private ☐ Other | **Dental Insurance:** ☐ Medicaid ☐ CHIP ☐ Private ☐ Other

Doctor/Dentist (of applying child)

Doctor Clinic Name	Address	City	State	Zip	Phone
Dentist Clinic Name	Address	City	State	Zip	Phone

Primary Adult Living in the Household

First	Middle	Last	Birthday

Gender	Race (*check all that apply*)	Ethnicity	Primary Language / Other Languages
	☐ Asian ☐ White ☐ Pacific Islander ☐ Black ☐ Native American ☐ Other _____	☐ Hispanic ☐ Non-Hispanic	Primary Language _____ Other Languages _____

Highest Grade Completed	Employment Status	Relationship to child	Email / Cell / Health Insurance
☐ Grade 9 or less ☐ Grade 10 ☐ Grade 11 ☐ Grade 12 ☐ High School Graduate ☐ Training Certificate ☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree	☐ Full-time ☐ Part-time ☐ Retired or Disabled ☐ Training or School ☐ Seasonally Employed ☐ Unemployed	☐ Parent (e.g. biological, adoptive, stepparents) ☐ Grandparent ☐ Foster parent- not including relatives ☐ Relatives- other than grandparents **Custody:** Yes ☐ No ☐	Email Address Cell Phone Number **Does this individual have Health Insurance** ❑ Yes ❑ No **If yes, Type of Insurance** ☐ Medicare ☐ State Health Plan ☐ Medicaid ☐ Employment Based ☐ Direct Purchase ☐ Military ☐ Other **Do you have a medical provider** ❑ Yes ❑ No

Secondary Adult Living in the Household

First	Middle	Last	Birthday

Gender	Race (*check all that apply*)	Ethnicity	Primary Language / Other Languages
	☐ Asian ☐ White ☐ Pacific Islander ☐ Black ☐ Native American ☐ Other _____	☐ Hispanic ☐ Non-Hispanic	Primary Language _____ Other Languages _____

Highest Grade Completed	Employment Status	Relationship to child	Email / Cell / Health Insurance
☐ Grade 9 or less ☐ Grade 10 ☐ Grade 11 ☐ Grade 12 ☐ High School Graduate ☐ Training Certificate ☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree	☐ Full-time ☐ Part-time ☐ Retired or Disabled ☐ Training or School ☐ Seasonally Employed ☐ Unemployed	☐ Parent (e.g. biological, adoptive, stepparents) ☐ Grandparent ☐ Foster parent- not including relatives ☐ Relatives- other than grandparents **Custody:** Yes ☐ No ☐	Email Address Cell Phone Number **Does this individual have Health Insurance** ❑ Yes ❑ No **If yes, Type of Insurance** ☐ Medicare ☐ State Health Plan ☐ Medicaid ☐ Employment Based ☐ Direct Purchase ☐ Military ☐ Other **Do you have a medical provider** ❑ Yes ❑ No

General/Family Information

Living Address	City	State	Zip
Mailing Address (if different)	City	State	Zip

Parental Status ❒ One ❒ Two	Primary Language at Home	Other Languages at Home

Housing Type(mark one): ☐ Homeless ☐ Own ☐ Rent ☐ Other Permanent Housing ☐ Other Please List:

Parent or guardian is an active duty member of the US Military? ❒ Yes ❒ No	Parent or guardian is a veteran of the US Military? ❒ Yes ❒ No

Non-Custodial Parent (Not living in the household)

First	Middle	Last	Birthday

Gender	Race (*check all that apply*)	Ethnicity	Primary Language / Other Languages	Custody:
	☐ Asian ☐ White ☐ Pacific Islander ☐ Black ☐ Native American ☐ Other _____	☐ Hispanic ☐ Non-Hispanic	Primary Language _____ Other Languages _____	❑ Yes ❑ No

Phone number	Address

Siblings of applying child			
Last	First	Birthday	Gender

At which Elementary School will your child attend Kindergarten?_____

Primary Site:	**Head Start Site Preferences:** (Choose preferences from list) **1.**_____ **2.**_____	**Preference list:** OWCAP, Bonneville, Your Community Connection, Marshall White Center	Roy, South Ogden, James Madison, 5-points/Harrisville, Ogden-Weber Technical College

Emergency Contacts other than parent.

The child will not be released to anyone other than the parents and persons listed below. **MUST BE at least 18 years old**

Contact 1	Name		Phone Type	Phone Numbers	Relationship to Child
	Address		Cell	( )	
	City		Home	( )	Emergency Contact? ❑ Yes ❑ No
	State	Zip	Work	( )	Release to? ❑ Yes ❑ No
Contact 2	Name		Phone Type	Phone Numbers	Relationship to Child
	Address		Cell	( )	
	city		Home	( )	Emergency Contact? ❑ Yes ❑ No
	State	Zip	Work	( )	Release to? ❑ Yes ❑ No
Contact 3	Name		Phone Type	Phone Numbers	Relationship to Child
	Address		Cell	( )	
			Home	( )	Emergency Contact? ❑ Yes ❑ No
	State	Zip	Work	( )	Release to? ❑ Yes ❑ No

Certification: By submitting this application, I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

***To be completed by agency staff: Enrollment Information. ***

Releases Signed? ❑ Yes ❑ No Date Signed:

Income Amount	Per	Annual Amount	Description	Verification	Note

Program Details		
Program/Term	Site	Application Date
Enrollment		
Eligibility Notes		
Eligibility		
Eligibility Income / Number in Family	Income Status	Participation Year

Is this child income eligible for Head Start? □Yes □No

Ogden-Weber Community Action Partnership, Inc.
Head Start/ Early Head Start Program

Eligibility Assessment Guide

For use in the 2022-2023Recruitment Year beginning January 1, 2022
[Agency Use Only Reference Sheet]

AREA	
	Only one adult living in household
	Child living with an adult other than Parent/Guardian. Who:_____
	Child in a: ☐ Kinship Placement ☐ State ordered Custody ☐ Foster Care (Documentation must be provided)
	Homeless living in shelter, campground, park, motel or car due to loss of housing or economic hardship?
	Homeless living with another family due to loss of housing or economic hardship?
	Family is receiving: ☐ FEP ☐ SSI (documentation must be provided)
	Parent had a child when they were 19 years old or younger ☐ Father ☐ Mother
	Current teen parent (19 years old and younger)
	Child is non-English speaking Please list language _____
	Child transferring from another Head Start Program
	Child is transitioning from OWCAP Early Head Start (during current program year)
	Child is transitioning from another Early Head Start Program (during current program year)
	Registering child enrolled in OWCAP HS/ EHS last school year
Other	
	Registering child has current IEP/IFSP (with documentation provided, initials_____)
	Registering child has a suspected disability
	Family receiving: ☐ food stamps ☐ WIC
	Domestic Violence (including emotional, verbal, psychological, and physical): ☐ Present ☐ Past
	Physical Abuse/Neglect: ☐ Present ☐ Past
	Child Protective Services Involvement: ☐ Present ☐ Past
	Substance abuse/use, including prescription drug abuse: ☐Present ☐Past
	Child has severe health problems that affect the child's learning
	Family referred by another agency/professional Referred by: _____
	Both parents currently unemployed
	Single parent unemployed
	Family directly impacted by COVID. Loss of ☐ Income ☐ Job ☐ Housing
	Parent(s) incarcerated ☐Present ☐Past
	Parent(s) Deported ☐ Present ☐ Past
	Parent has less than a High School diploma or GED ☐ Father ☐ Mother
	Currently enrolled in High School, Adult Education/Diploma, GED, or Trade School(not ESL)
	Parent(s) Deployed currently or on the past 12 months
	Gas, water or electricity was turned off in the last 12 months How many times? _____

Income **FOR STAFF USE ONLY			
	Eligible		131-150% (Over)
	101-110% (Moderate)		151-175% (Over)
	111-120% (Moderate)		176-200% (Over)
	121-130% (Moderate)		Over 200% (Over)

Twins/Multiple births receive the same points (based on the highest points of the two applications) so both children are considered for selection at the same time.

Approved by Policy Council: 11/11/2021
Board of Trustees Approval:

Head Start / Early Head Start Consent Form

Participant Name: _____ Date of Birth: _____

I give consent/authorization for OWCAP Head Start/Early Head Start for the following:	Yes	No
Physical Examination- Weber State Nursing Program, additional information is given prior		
Blood Pressure-Measure of blood pressure (Ages 3 years old and older)		
Hematocrit/Hemoglobin -Measure using a non-invasive light sensor using child's finger		
Growth Assessment-Measure child's height and weight		
Lead Screening-Partnership with Midtown Clinic, additional information is given prior		
Dental Examination-Partnership with local Dentist, additional information is given prior		
Behavior/Mental Health Services-Observation, evaluation, consultation and counselling services to families and children in and outside of the classroom		
Hearing Screening-Listening machine or acoustic machine/device		
Vision Screening-Utilizing a vision camera screening device		
Behavior/Social & Emotional Screener		
Developmental		
Autism Screener-Autism screener for children ages 18 months and at 24 months		
Apply Fluoride Varnish- WSU Dental Hygienist Program, additional information is given prior		
Apply Sunscreen -Sunscreen is provided and applied by teaching staff, as needed		
Apply Lotion- Lotion is provided and applied to dry skin by teaching staff, if needed		
Offsite educational activities-Child may participate in walking field trips, Advance notice given		
Videos & Photographs-Included in photos and videos that may be used in the classroom		
Videos & Photographs-Included in photos and videos that may be used outside of the classroom		
Transportation- Transport my child in case of an emergency		

Parent Interests	Yes	No
Serving on the OWCAP Head Start Policy Council (similar to school PTA)		
Serving on the Fatherhood Committee (Father/Father Figures only)		
OWCAP/WSU in-home Family Literacy Project		
Nicotine Cessation Resources (Resources to stop smoking, vaping, ect.)		

I understand that I may revoke this consent, in writing to Head Start/Early Head Start, any time before the expiration date. This release will expire at the end of the program year. Program may use photographs and videos beyond the program year.

_____ _____

Parent/Guardian Signature Date

Child Health and Nutrition Assessment

Participant Name: _____ Date of Birth: _____

Allergies:	**Yes**	**No**
Does your child have any allergies that have been verified by a physician and require medications in the classroom?		
If yes, please list:		

***Before child starts class, please bring documentation from your child's physician regarding the allergies you have listed.**

Please mark all current medical conditions and needed classroom accommodations that apply to your child:					
	Diabetes		Vision problems/wears glasses		Seasonal allergies
	Seizures		Asthma		Allergies to insects/bee stings
	Birth defects		Ear Infections		Eczema/skin irritation
	Heart defects		Hearing Problems/Aids		
	Bone, joint, or muscle deformity (please list):				
	Serious Injuries (please list):				
	Other- physical and/or behavioral (please list):				

Special Meal Accommodations:	**Yes**	**No**
Does your child have special dietary requirements needed for the class time meals (cultural, religious, eating patterns, specialized formula, food allergies or intolerances)?		
If yes, please list:		

***Medical Provider documentation required.**

Please mark all current conditions that need classroom accommodations that apply to your child:					
	Anemia		Tube feeding		Diabetes
	Malnutrition		Vitamin and/or mineral deficiencies		Overweight
	Swallowing difficulties		Sensorial accommodations		Underweight
	Feeding concerns		Breastfeeding		Frequent constipation
	Chewing difficulties		Lactose intolerant		
	Other:				

Would you like to be contacted by our Dietitian to set up Nutrition Counseling sessions for you or your child? ❒ Yes ❒ No

Please mark all that apply to your child:	**Yes**	**No**
Does your child use an inhaler and will need to use it during class time?		
Has your child had any recent operations that need classroom accommodations?		
If yes, please explain:		
Has your child been exposed to violence or other traumatic experiences?		
If yes, please explain:		

Parent/Guardian Signature: _____ Date: _____

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Head Start/ Early Head Start Program

Parent Responsibilities Form

Child's Name: _____ Date of Birth _____

Please initial after reading all of the following statements below:	
	I understand that I must inform the teacher of any medical concerns regarding my child.
	I understand that Head Start/Early Head Start is a program for the **entire family.**
	I understand I will receive a "Field Trip Parental Permission" form before each field trip. This form will need to be signed and returned before your child can attend the field trip.
I understand that the following documentation and verifications are required:	
	Income Verification
	Child's **CURRENT** Immunization Record
	Verification of birth date (Birth Certificate)
	Well-child exam
	Dental exam
(Please contact the Health Team at 801-399-9281, if you need help in obtaining a well-child or dental exam.)	
After acceptance into Head Start/Early Head Start I agree:	
	Participate in the orientation process
	To inform Head Start/Early Head Start if I change my address or telephone numbers.
	To volunteer time and support to Head Start/Early Head Start. This may include, but not be limited to classroom involvement and working on your child's goals.
	Participate in 2 home visits and 2 parent/teacher conferences with my child's teacher
	To participate in home visits and family assessments with the Family Service Worker Assigned to my family. (Weekly visits for our home-based program option)
	To attend monthly parent and child engagement activities or socialization activities.
	To call the teachers or Family Service Worker and let them know why my child is absent; **within 1 hour of the class start time**.
	To have parent or authorized adult (18 years or older) drop off and pick up my child at the assigned time. **Signing the child in and out is required.**

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Staff Date