



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. Please refer to our website or call for registration dates and appointments.

- **Early Head Start/Prenatal Program**- is to support pregnant women and expectant fathers. Prenatal Care and Education offered.
- **Early Head Start** is for children under the age of 3. OWCAP offers a home based and a center based option.
- **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.

When you come to registration. Please have the following items with you, if possible:

<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> Immunization Record	<input type="checkbox"/> Proof of Address (utility bill, picture ID, ect.)
<input type="checkbox"/> Proof of Income for the past 12 months One of the following: <ul style="list-style-type: none"> • Last year's w-2 form • Tax form 1040 • Current financial assistance printout from DWS (FEP, SNAP, TANF) • 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: <input type="checkbox"/> Physical Exam (to include Blood Pressure, Hemoglobin, Lead Test) <input type="checkbox"/> Dental Exam (to include cleaning, fluoride, treatments)

Frequently Asked Questions:

<p>Does my child have to be potty trained to attend Head Start?</p> <ul style="list-style-type: none"> • No, our teachers are trained to work with children and the parent to help with potty training.
<p>Is there an attendance requirement for my child to attend Head Start/Early Head Start?</p> <ul style="list-style-type: none"> • 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.
<p>What is the Home-Based Program?</p> <ul style="list-style-type: none"> • 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]
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3159 Grant Ave
Ogden, UT 84401

HS
 EHS

OWCAP Head Start/Early Head Start Application Family Member Information



Child Applying for Head Start/Early Head Start						
First		Middle		Last		Preferred
Birthdate	Gender	Race (check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> Native American <input type="checkbox"/> Other _____			Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
						Primary Language _____ Other Languages _____
Medical Insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP <input type="checkbox"/> Private <input type="checkbox"/> Other				Dental Insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP <input type="checkbox"/> Private <input type="checkbox"/> 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		Birthdate
Gender		Race (check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> Native American <input type="checkbox"/> Other _____			Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
						Primary Language _____ Other Languages _____
Highest Grade Completed <input type="checkbox"/> Grade 9 or less <input type="checkbox"/> Grade 10 <input type="checkbox"/> Grade 11 <input type="checkbox"/> Grade 12 <input type="checkbox"/> High School Graduate <input type="checkbox"/> Training Certificate <input type="checkbox"/> Associate's Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree		Employment Status <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired or Disabled <input type="checkbox"/> Training or School <input type="checkbox"/> Seasonally Employed <input type="checkbox"/> Unemployed		Relationship to child <input type="checkbox"/> Parent (e.g. biological, adoptive, stepparents) <input type="checkbox"/> Grandparent <input type="checkbox"/> Foster parent- not including relatives <input type="checkbox"/> Relatives- other than grandparents Custody: Yes <input type="checkbox"/> No <input type="checkbox"/>		Email Address _____ Cell Phone Number _____
						Does this individual have Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Type of Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> State Health Plan <input type="checkbox"/> Medicaid <input type="checkbox"/> Employment Based <input type="checkbox"/> Direct Purchase <input type="checkbox"/> Military <input type="checkbox"/> Other Do you have a medical provider <input type="checkbox"/> Yes <input type="checkbox"/> No
Secondary Adult Living in the Household						
First		Middle		Last		Birthdate
Gender		Race (check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> Native American <input type="checkbox"/> Other _____			Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
						Primary Language _____ Other Languages _____
Highest Grade Completed <input type="checkbox"/> Grade 9 or less <input type="checkbox"/> Grade 10 <input type="checkbox"/> Grade 11 <input type="checkbox"/> Grade 12 <input type="checkbox"/> High School Graduate <input type="checkbox"/> Training Certificate <input type="checkbox"/> Associate's Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree		Employment Status <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired or Disabled <input type="checkbox"/> Training or School <input type="checkbox"/> Seasonally Employed <input type="checkbox"/> Unemployed		Relationship to child <input type="checkbox"/> Parent (e.g. biological, adoptive, stepparents) <input type="checkbox"/> Grandparent <input type="checkbox"/> Foster parent- not including relatives <input type="checkbox"/> Relatives- other than grandparents Custody: Yes <input type="checkbox"/> No <input type="checkbox"/>		Email Address _____ Cell Phone Number _____
						Does this individual have Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Type of Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> State Health Plan <input type="checkbox"/> Medicaid <input type="checkbox"/> Employment Based <input type="checkbox"/> Direct Purchase <input type="checkbox"/> Military <input type="checkbox"/> Other Do you have a medical provider <input type="checkbox"/> Yes <input type="checkbox"/> No
General/Family Information						
Living Address			City	State	Zip	
Mailing Address (if different)			City	State	Zip	
Parental Status <input type="checkbox"/> One <input type="checkbox"/> Two		Primary Language at Home			Other Languages at Home	
Housing Type(mark one): <input type="checkbox"/> Homeless <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Other Permanent Housing <input type="checkbox"/> Other Please List:						
Parent or guardian is an active duty member of the US Military? <input type="checkbox"/> Yes <input type="checkbox"/> No				Parent or guardian is a veteran of the US Military? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Non-Custodial Parent (Not living in the household)						
First		Middle		Last		Birthdate
Gender		Race (check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> Native American <input type="checkbox"/> Other _____			Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
						Primary Language _____ Other Languages _____
						Custody: <input type="checkbox"/> Yes <input type="checkbox"/> 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)	Preference list: OWCAP Bonneville Your Community Connection Marshall White Center	Roy
	1. _____ 2. _____		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	()	Emergency Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No Release to? <input type="checkbox"/> Yes <input type="checkbox"/> No
	City		Home	()	
	State	Zip	Work	()	
Contact 2	Name		Phone Type	Phone Numbers	Relationship to Child
	Address		Cell	()	Emergency Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No Release to? <input type="checkbox"/> Yes <input type="checkbox"/> No
	city		Home	()	
	State	Zip	Work	()	
Contact 3	Name		Phone Type	Phone Numbers	Relationship to Child
	Address		Cell	()	Emergency Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No Release to? <input type="checkbox"/> Yes <input type="checkbox"/> No
			Home	()	
	State	Zip	Work	()	

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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

For use in the 2023-2024 Recruitment Year beginning January 1, 2023

AREA	
	Only one adult living in household
	Child in a: <input type="checkbox"/> Kinship Placement <input type="checkbox"/> State ordered Custody <input type="checkbox"/> 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: <input type="checkbox"/> FEP <input type="checkbox"/> SSI <input type="checkbox"/> SNAP (Documentation must be provided)
	Parent had a child when they were 19 years old or younger <input type="checkbox"/> Father <input type="checkbox"/> Mother
	Current teen parent (19 years old and younger)
	Child is non-English speaking Please list language _____
	Child is transitioning from OWCAP Early Head Start (during current program year)
	Child is transitioning from another Early Head Start or Head Start Program (during current program year, documentation must be provided)
	Registering child enrolled in OWCAP HS/ EHS last school year
Other	
	Registering child has current IEP/IFSP (Documentation must be provided)
	Family receiving: WIC
	Domestic Violence (including emotional, verbal, psychological, and physical): <input type="checkbox"/> Present <input type="checkbox"/> Past
	Physical Abuse/Neglect: <input type="checkbox"/> Present <input type="checkbox"/> Past
	Child Protective Services Involvement: <input type="checkbox"/> Present <input type="checkbox"/> Past
	Substance abuse/use, including prescription drug abuse: <input type="checkbox"/> Present <input type="checkbox"/> 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
	Parent(s) Justice Served (incarcerated) <input type="checkbox"/> Present <input type="checkbox"/> Past
	Parent(s) Deported <input type="checkbox"/> Present <input type="checkbox"/> Past
	Parent has less than a High School diploma or GED <input type="checkbox"/> Father <input type="checkbox"/> Mother
	Currently enrolled in High School, Adult Education/Diploma, GED, or Trade School (not ESL or College)
	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.



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 Screener		
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		
Apply Diaper Rash Cream- Over the counter and is provided and applied 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?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list:		

***Before child starts class, documentation from your child’s physician regarding the allergies you have listed is required.**

Please mark all current medical conditions needing classroom accommodations that apply to your child:					
	Diabetes		Wears glasses		Seasonal allergies
	Seizures		Asthma		Allergies to insects/bee stings
	Birth defects		Ear Infections		Eczema/skin irritation
	Heart defects		Hearing Problems/Aids		Sensorial accommodations
	Anemia		Tube feeding		Breastfeeding
	Bone, joint, or muscle deformity (please list):				
	Serious Injuries (please list):				
	Other (please list):				

Special Meal Accommodations:	Yes	No
Does your child have special dietary requirements needed for the class time meals (cultural, religious, medical, specialized formula, food allergies or intolerances)?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list:		

***Medical Provider documentation is required.**

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?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child had any recent operations that need classroom accommodations?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain:		
Has your child been exposed to violence or other traumatic experiences?	<input type="checkbox"/>	<input type="checkbox"/>
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 UP TO DATE Immunization Record
	Verification of birth date (Birth Certificate)
	Well-child exam (to include blood pressure, Hemoglobin, Lead Test)
	Dental exam (to include cleaning, fluoride, and any dental treatment needed)
(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:	
	Attend orientation
	To inform Head Start/Early Head Start if I change my address, telephone numbers or email address.
	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 when my child is absent; within 1 hour of the class start time.
	To have parent or authorized adult (<u>must be 18 years or older</u>) pick up my child at the assigned time. Signing the child in and out is required. Picture ID is required.

Signature of Parent/Guardian

Date