PLEASE READ THIS BEFORE YOU TURN IN YOUR APPLICATION!

Upon completing an application for enrollment, the Early Head Start Home Based manager will complete the Enrollment Selection Criteria for every child. Children will be accepted into the Early Head Start Home Based Program based on total points received from this form, as well as available space. Eligibility factors include but are not limited to: Income Eligibility (the Federal Poverty Guidelines are used for this), Special Needs, age of child, need for services, and other factors. While GTB Members are given priority when income eligibility factors are met, this program is open to all individuals regardless of Tribal Affiliation.

Your Home Visitor will assist you in completing this application if needed. Please note all required information (other then income) MUST be turned into your Home Visitor within 90 days of enrollment. If the required information is not turned into the Home Visitor within 90 days, home visits could be suspended until information is received.

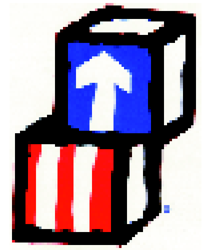
INCOME VERIFICATION MUST BE TURNED IN WITH YOUR APPLICATION. APPLICATIONS TURNED IN WITHOUT INCOME VERIFICATION CANNOT BE CONSIDERED FOR ACCEPTANCE. Please submit your 1040 tax return or your W2's from 2019. If you did not file taxes, please submit income verification for the past 12 months which includes: Wages/Salary, Unemployment Compensation, Per Capita Payments, other Trust Money payments, Child Support Payments, SSI payments.

When all openings are filled, a waiting list will be established for those children not enrolled. The children on the waiting list will be selected in order of eligibility. This means that children who are more income eligible, have special needs, etc. will be selected first, regardless of when their application was received.

If you have any questions or concerns regarding the application process or enrollment for the Home-Based Program please contact Leona Burfield at 231-534-7929.

- Your child's birth certificate
- Your child's insurance information
- Your child's Tribal ID (if applicable)
- Immunization record
- Current physical exam
- Current dental exam (after first tooth erupts)

Grand Traverse Band
Early Head Start, Head Start & GSRP
Enrollment Application
2020-2021



2605 NW Bay Shore Drive
Peshawbestown, MI 49682
Phone: (231)534-7650 FAX (231)534-7583

Please indicate which program you are applying for: ☐Head Start/GSRP ☐Center-Based Early Head Start ☐Home-Based Early Head Start

Applicant Information: (Child or Expectant Woman)

First Name Middle Name Last Name	Date of Birth:	Gender: ☐Male ☐Female

Address where applicant/child resides:	**Mailing Address:**
Street:	Street/PO Box:
City: State: Zip Code:	City: State: Zip Code:
County:	School District:

What is the Applicant's Race:	**What is the Applicant's Ethnicity:**	**Is Applicant a:**	**Is Applicant Currently:**
☐American Indian/Alaskan Native ☐White ☐Black/African American ☐Bi-racial/multi-racial ☐Asian ☐Native Hawaiian or other Pacific Islander ☐Other:_______________	☐Hispanic or Latino origin ☐Non-Hispanic or Non-Latino Origin	☐GTB Member ☐Member of another Tribe: _____ ☐Not Affiliated with any Tribe **Language(s) spoken in the child's home?** Primary:________________ Secondary:________________	☐Enrolled in Head Start ☐Enrolled in Early Head Start ☐Home Based ☐Not Previously Enrolled in Head Start or Early Head Start

Applicant's Custodial Information:

☐Does not apply in my situation
☐Sole Custody
☐Joint Custody—both biological parents
☐Joint Custody—other; Explain:________________________________
☐Physical Custody: Explain who has legal custody:__________________
☐Foster Care (Please explain and provide a copy with your application)
Caseworker:____________________
Phone:________________________

Is there a protection or restraining order regarding the child? ☐No ☐Yes (Please explain and provide a copy with your application)	Are there special visitation orders we should be aware of? ☐No ☐Yes (Please explain and provide a copy with your application)

Household Composition: List the Primary Caregivers

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Other:____________________

Primary Adult Lives with Child: ☐ Yes ☐No

First Name: Last Name:	**Are you employed:**
Date of Birth: Relationship To Child:	☐Part time ☐Full Time ☐Seasonally ☐US Military-Active Duty ☐Retired ☐Unemployed ☐Self Employed ☐Disabled Employer Name:______________________________
Is Parent/Guardian a: ☐GTB Member ☐Member of Another Tribe__________________	**Are you attending school/job training:** ☐Yes ☐No
Telephone Number/Contact Information: Home:__________________ Work:________________ Cell Phone:________________ Message:______________ E-Mail Address: ______________________________	**Highest level of education completed:** ☐9th grade or less ☐10th grade ☐11th grade ☐High School Graduate ☐GED ☐Training Certificate ☐Vocational ☐Associates ☐Bachelor ☐Master's ☐Advanced ☐Other:________________________

Primary Adult Lives with Child: ☐ Yes ☐No

First Name: Last Name:	**Are you employed:**
Date of Birth: Relationship To Child:	☐Part time ☐Full Time ☐Seasonally ☐US Military-Active Duty ☐Retired ☐Unemployed ☐Self Employed ☐Disabled Employer Name:______________________________
Is Parent/Guardian a: ☐GTB Member ☐Member of Another Tribe_________________	**Are you attending school/job training:** ☐Yes ☐No
Telephone Number/Contact Information: Home:__________________ Work:________________ Cell Phone:________________ Message:______________ E-Mail Address: ______________________________	**Highest level of education completed:** ☐9th grade or less ☐10th grade ☐11th grade ☐High School Graduate ☐GED ☐Training Certificate ☐Vocational ☐Associates ☐Bachelor ☐Master's ☐Advanced ☐Other:________________________

Other Household Member Information: Please list *all* other persons living within the home not listed above

First Name	Last Name	Date of Birth	Relationship to Child

Additional Information:

Is there anyone in your household currently pregnant? ☐No ☐Yes Due Date:____________________

Child Care Provider Information:

Will this child be cared for by someone other than you, in addition to participating in this program? ☐Yes ☐No
If yes, please complete the following information:

☐Child Care Center ☐Relative's Home or at Child's home by Relative
☐Family Child Care Home ☐Other:__________________________
☐Need assistance finding child care

_____ Number of hours per day child care is needed

Family Resource Information:

Does your family receive any of the following types of services or financial assistance? (Check all that apply)

☐Medicaid/Medicare
☐WIC - County________________
☐Supplemental Security Income (SSI)
☐Refugee Assistance Program
☐SNAP/Bridge Card
☐Child Support
☐State Disability Assistance (for yourself or someone in your care)
☐Cash Assistance (from DHS)
☐Child Care Assistance (from DHS) (Tribal)
☐State Emergency Relief Programs
☐Other: ___________________

What is your current living arrangement/situation: ☐Own ☐Rent ☐Motel ☐Receive Subsidized Housing
☐Shelter ☐Experiencing homelessness—live with others because I have no alternative ☐Live with relatives/friends by choice
How long have you lived at this address:_____________ ☐Other, Specify_____________________

In order to best meet the needs of your family, please indicate if your family receives or is in need of any of the following services:
Please write an "N" in the box by those services that you need or would like additional information, and write an "R" in the box by those services that you are currently receiving.

☐Crisis Assistance
☐Food
☐Housing
☐Clothing
☐Transportation
☐Parenting Education
☐Employment
☐Mental Health
☐Literacy
☐English as a Second Language
☐Adult Education
☐Relationship/Marriage Education
☐Legal Assistance
☐Job Training
☐Substance Abuse Prevention
☐Substance Abuse Treatment
☐Child Abuse/Neglect Services
☐Prenatal Education
☐Budgeting Information
☐Domestic Violence Services
☐Child Support Assistance
☐Health Education
☐Assistance to families of Incarcerated Individuals
☐Other:______________

Health, Nutrition & Developmental Information:

Applicant's Physician/Health Care Provider Name:	Address:	Date of Last Exam:

Health Care Coverage Information:
☐Medicaid ID #____________________________ ☐Contract Health ☐No Health Care Coverage
☐Private Health Insurance Policy #______________________________

Applicant's Dentist/Dental Care Provider Name:	Address:	Date of Last Exam:

Dental Coverage Information: ☐No Coverage ☐Medicaid ☐Private Insurance (please list):

Does the applicant have any health conditions such as: Allergies (to foods, medications, insect bites, seasonal, etc.), Diabetes, Asthma, Seizures, or any other conditions? ☐Yes ☐No (If yes, medical documentation is needed)
If yes, please list and explain if there is a protocol for emergency intervention:____

Does the applicant have any special dietary needs? ☐Yes ☐No Are they diagnosed by a health care professional? ☐Yes ☐No
If yes, please explain:____

Do you have any concerns about your child's development? ☐Yes ☐No
If yes, please describe:____

Child's Birth Weight: _____lb _____oz

Was child born more than 3 weeks early or late? ☐Yes ☐No
If yes, please explain:

Did the child's mother visit the doctor LESS than 2 times during pregnancy?
☐Yes ☐No

Did the child's mother have any health problems during pregnancy or delivery of this child?
☐Yes ☐No
If yes, please explain:____

Has your child been diagnosed with a disability? ☐Yes ☐No
If yes, please list:____

Is the applicant receiving any special services or currently on an IEP (Individual Education Plan) or IFSP (Individual Family Service Plan)? (i.e., medical, speech therapy, physical therapy, occupational therapy, early childhood special education, etc.)
☐Yes ☐No
If yes, please describe and list name of provider:____

Certification: 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. I understand that this is an application only and does not guarantee enrollment into the Early Head Start/Head Start/GSRP Programs.

Parent/Guardian Signature: **Date:**

FOR OFFICE USE ONLY

Interview completed in person ☐ By phone ☐

Applicant interviewed by: Date: Birth Verified ☐Yes ☐No Income Verified ☐Yes ☐No

GTB EARLY HEAD START, HEAD START & GSRP revised 4/2020
2600 N. Strongheart Way
Suttons Bay, MI 49682
(231)534-7650 / FAX (231)534-7583

CONSENT FOR PARTICIPATION

Child's Name:___________________________________
I, the undersigned, hereby give permission to the Grand Traverse Band Early Head Start/Head Start/GSRP Programs to:

PLEASE INITIAL:

________ Release and Obtain **ALL** Health Records of my child including to and from my child's primary care physician, dental care provider, ophthalmologist, and/or any other pertinent health provider's information.

________ Obtain and share information regarding my child with DHS.

________ Obtain and share information regarding my child with Health Department/WIC.

________ Obtain and share information regarding my child with GTB Behavioral Health Services.

________ Obtain and share information regarding my child with AFS.

________ Obtain and share information regarding my child with Pine Rest/Mental Health Therapist/Consultant________________________.

________ Allow my child to participate in Head Start's Free Health Care Program which could include all or some of the following:

*Immunization Clinic	*Dental Examination
*Physical Examination	*Speech Evaluation/Therapy/OT/PT
*Early Intervention Staff	*TBAISD/Early-On
*Hearing and Vision Testing	*Height & Weight Measurements
*Developmental Screening/s	*Tooth brushing daily with Fluoridated Toothpaste
* Hemoglobin & Blood Pressure Screening	*Referrals to other agencies for Disability Services
*Child observations and/or staff consultations regarding my child with Mental Health Consultant, Nutrition/Dietician Consultant, and/or Nursing Consultant if needed.	

________ Release my name, phone number, and the name, birth date, address, and pertinent Head Start file contents of my child to the school of my choice:___________________________ . This will be done when my child is age eligible for Kindergarten Round-Up activities.

________ To take photographs and/or videos of my child/family which may be used in displays, recruitment, or other types of news/educational publications. Occasionally local news media may take photographs or video of the children.

________ Release my child's name on a class list which will be distributed to all parents/guardians. Allow my child's name to appear in class, program or promotional material.

______ Allow Head Start/Early Head Start staff to apply sunscreen (SPF 45) to my child before going outside in spring/summer months.

**This consent is valid for one year after the date signed. In signing this document, I am fully aware of the items listed and concur that the above consent is in the best interest of my child.

____ ______________________________
Signature of Parent/Guardian Date