Providing Free or Low Cost Quality Early Learning Services in Freeborn County

Please fill out the front and back page of the application in black or blue ink, and please PRINT CLEARLY. Sign and date the application and attach proof of all income.

Mail to: Families First Head Start

126 Woodlake DR SE, Rochester, MN 55904

Or drop off at: Brookside Education Center, Head Start Office Room 122, office hours Monday through Friday 8 a.m. to 5 p.m.

Please keep this page for your reference.

Children and families with the greatest need have the highest priority for enrollment. Placements are made according to child and family needs, parent choice, and available openings. Head Start will do its best to enroll your child, but space is limited.

IMPORTANT: We will contact every family who applies for Head Start. Please tell us if your phone number or address changes. Applications also available at www.familiesfirstmn.org.

Early Head Start is:

- **For pregnant mothers infants and toddlers up to age 3**
- If accepted, this program will be no cost to your family
- Early Head Start is an all year program
- Weekly home visits
- Services provided for children with special needs

Head Start is:

- **For children who are 3 or 4 on or before September 1, 2017**
- If accepted, this program will be no cost to your family
- Busses are available to SOME areas
- Classes runs 4 days per week
- Services provided for children with special needs

If you need help or have questions, call us.

For English call 507-287-2009

For Español call 507-287-2009

For Arabic and (Soomaaliga) Somali call 507-287-2009

For Toll Free call 1-800-462-1660

Families First OF MINNESOTA

"Ensuring positive beginnings for all young children and their families."

Families First of Minnesota is an equal opportunity provider and employer.

DATA PRIVACY RIGHTS OF APPLICANTS OF CHILD CARE RESOURCE & REFERRAL, INC.

RIGHT TO KEEP INFORMATION ABOUT YOU PRIVATE (DATA PRIVACY)

Most of the information we collect about you will be classified as private. That means you and the agency collecting the data can see it; others cannot. Occasionally, statistics and other anonymous data will be taken from the information we collect about you or your family. This is public and open to anyone, but it will not identify you in any way.

In a few cases, information we collect is classified confidential. Confidential data is not open to anyone (not even you) except the government agencies that need it. Data in this category deals with civil or criminal investigation, some medical data, and the names of persons who report child or vulnerable adult abuse.

Purpose of Information

The information you are asked to provide will be used to determine program eligibility, to coordinate services between programs, to verify program services being provided, and to provide us with a mailing list. This list will be used to update you on upcoming programs and program changes and to inform you of eligibility for programs within Families First of Minnesota. Only Head Start or School Readiness Families First staff and funding source employees whose jobs require access to this information, as well as Federal or State Auditors, may have access to your information.

RIGHT TO ACCESS YOUR RECORDS

Access by you. You can see all public and private records about yourself and your children. To see your file, call Families First of Minnesota during agency hours and make a request to review your files within five working days by contacting the program from which you are receiving service. Review will take place on site during working hours.

Access by agency. Employees of this agency will have access to information about you any time their work requires it. By law, some other government and contractor agencies will also have access to certain information about you if they provide a service to you or if they provide a service to this agency that affects you and requires access to your records. They may include school districts, public health, social services and financial assistance.

FAMILIES FIRST OF MINNESOTA

Application for Early Head Start and Head Start

126 Woodlake DR SE, Rochester, MN 55904 • Phone (507) 287-2009 • 1 (800) 462-1660 • Fax (507) 287-2411

PLEASE FILL OUT FRONT AND BACK OF THE APPLICATION; SIGN AND DATE. PLEASE PRINT CLEARLY. **If you need help, please call.**

Home Address for Family		**Home Phone Number**
City	**State** **Zip Code**	**Cell Phone Number**
Email Address *(please print clearly)*		**Phone Number of other person if we cannot contact you** _____
Do you speak English? ☐ Yes ☐ No **How well?** None Little Average Very Well	**Language spoken at home** _____ **Do you need an interpreter?** ☐ Yes ☐ No	**Can you drive your child to and from school if a bus is not available?** ☐ Yes ☐ No
Is your family expecting a baby? ☐ Yes ☐ No →If yes, due date: _____ **Do you want to apply for Early Head Start Services as a pregnant mother?** ☐ Yes ☐ No		**Number of People living in your Home** _____ **Number of People in your Family** _____

Marital Status (choose one): ☐ Married ☐ Married but living apart ☐ Divorced ☐ Widowed ☐ Single Living with Partner ☐ Single	**Type of medical insurance for <u>each applicant</u>:** ☐**Blue Plus** ☐**Ucare** ☐**None** ☐**Other :** _____
Mother/Guardian-Employment status: (Check all that apply) ☐ Full Time ☐ Part Time ☐ Seasonal/On-Call ☐ Retired/Disabled ☐ Training or School ☐ Military ☐ Unemployed: **Date Last Worked:** _____ **Name of employer(s)**_____**Date Started**:_____	**Father/Guardian-Employment status: (Check all that apply)** ☐ Full Time ☐ Part Time ☐ Seasonal/On-Call ☐ Retired/Disabled ☐ Training or School ☐ Military ☐ Unemployed: **Date Last Worked:** _____ **Name of employer(s)**_____**Date Started**:_____
<u>Mother/Guardian-Highest level of Education</u>: ☐ High School Diploma/GED ☐ Associates ☐ Bachelors ☐ No Education ☐ Completed Grade _____ ☐ Masters or higher	**<u>Father/Guardian-Highest level of Education</u>:** ☐ High School Diploma/GED ☐ Associates ☐ Bachelors ☐ No Education ☐ Completed Grade _____ ☐ Masters or higher

<u>Fill out all information for EACH person living in your home</u>. <u>Please print clearly</u>. <u>CIRCLE the program each applicant is applying for</u>. Programs you can apply for: **EHS** = Early Head Start (for pregnant mothers and children up to age 3)

HS = Head Start (for children age 3 or 4 on or before Sept. 1, 2017)

FIRST NAME	**LAST NAME**	**BIRTH DATE**	**SEX**	**RACE** (use code below)	**ETHNICITY** (Circle **<u>ONE</u>**)	**RELATIONSHIP TO YOU**	**RELATIONSHIP TO OTHER PARENT**	**Applicants only—** circle **<u>ALL</u>** program(s) applying for:	
1. Mother/ Parent Guardian (If living in home)		/ /	M F		Hispanic Non Hispanic				
2 Father/ Parent Guardian (If living in home)		/ /	M F		Hispanic Non Hispanic				
3.		/ /	M F		Hispanic Non Hispanic			EHS	HS
4.		/ /	M F		Hispanic Non Hispanic			EHS	HS
5.		/ /	M F		Hispanic Non Hispanic			EHS	HS
6.		/ /	M F		Hispanic Non Hispanic			EHS	HS
7.		/ /	M F		Hispanic Non Hispanic			EHS	HS
8.		/ /	M F		Hispanic Non Hispanic			EHS	HS
9.		/ /	M F		Hispanic Non Hispanic			EHS	HS

ENTER CODE FOR **<u>RACE</u>**: NA/AN= American Indian or Alaska Native A = Asian B = Black or African American

NH/PI = Native Hawaiian or Other Pacific Islander W= White M = Multi-racial

(continued on back)

Please check below ***ALL*** items affecting your family. This helps us to understand your family's needs and priority for enrollment. Please explain items you check.			
	Foster child or child in custody of a relative		Family member(s) with no health insurance
	Child with a special need, IFSP or IEP (child name) _____		Abuse of alcohol or drugs by either parent
	Child separated from parent due to jail/prison, military deployment or deportation		Refugee status in last five years
	Death of a child's parent or sibling		Family member with a mental health concern
	Family violence or domestic abuse or order of protection		Moved many times
	Serious medical condition or disability of child's parent or sibling		Other difficulties causing great stress (please explain):
	Child Protection Involvement		
	Significant decrease in family income within last 12 months		NONE of these items are affecting my family

CHECK BELOW ALL CHILD SUPPORT & PUBLIC ASSISTANCE AND ALL INCOME THAT YOUR FAMILY RECIEVES.

PROOF OF ALL INCOME IS REQUIRED WITH YOUR APPLICATION TO DETERMINE ELIGIBILITY

Check any of the following your family receives:

☐ MFIP (Cash Only)

☐ Child Care Assistance

☐ SSI (Supplemental Security Income)

☐ DWP (Diversionary Work Program)

☐ Refugee Match Grant

☐ None of these

From what County do you receive these from?

_____

Please answer the following:

Total monthly income before taxes: $_____

Does anyone in your family receive child support? ☐ Yes ☐ No

If Yes, what county? _____

Has anyone filed for child support? ☐ Yes ☐ No

If Yes, what County? _____

Who has custody of the child applicant(s)? _____

Has anyone received Financial Aid Grants or any Scholarships in the last year?

☐ Yes ☐ No

Has anyone received payments from Unemployment, Workers Comp, or Social Security in the last year? ☐ Yes ☐ No

What is your current living situation? *(check **ONE**)*

	Own, Rent or Share housing by choice		Living in a hotel, motel, campground, car, etc.
	Sharing housing due to loss of housing or economic hardship		Home in foreclosure or getting evicted. Eviction date:_____
	Staying at a shelter or Transitional Housing		Other (please explain) _____

For families with children ages birth to 3 years

I am interested in the Early Head Start weekly home visit program. ☐ Yes ☐ No

For all families

My child(ren) stay(s) home all day ☐ Yes ☐ No

My child(ren) stay(s) with a relative/neighbor/caretaker/daycare: Name and Address:_____

Who referred you to our programs? *(check All that apply)*

	Adult Basic Education or other Adult Literacy Program		Early Childhood Special Education		Social or Human Service Agency
	Child Care Program		Freeborn County Public Health		Friends or Family
	Early Childhood Screening		Health Care Provider		Other (please specify)

I give permission to Families First of Minnesota Head Start to verify my income and any materials related to my eligibility or enrollment. This includes authorization to verify any public assistance or child support that I may receive from the county I'm working with.

I give permission to Families First of Minnesota to exchange my child's name, DOB, Parent name and Phone number with the Albert Lea School District 241 for purposes of finding a preschool placement.

To the best of my knowledge the information I have given is accurate and true.

Parent/Guardian Signature _____Print Name:_____ Date: _____

Did someone help you fill out this application? ☐ No ☐ Yes ➡If yes, Name of person helping you: _____

Phone # (_____)_____-_____ May we contact this person regarding your application? ☐ Yes ☐ No