

Providing Free or Low Cost Quality Early Learning Services in Rice 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

Please keep this page for your reference.

Children and families with the greatest need have the highest priority for enrollment. 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 infants and toddlers up to age 3 who are enrolled in participating childcare centers**
- If accepted, this program will be no additional cost to your family
- Early Head Start is an all year program
- Monthly parent groups
- 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

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 in Rice County

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? <input type="checkbox"/> Yes <input type="checkbox"/> No How well? None Little Average Very Well		Language spoken at home _____ Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is your family expecting a baby? <input type="checkbox"/> Yes <input type="checkbox"/> No → If yes, due date: _____			Number of People living in your Home _____ Number of People in your Family _____

Marital Status (choose one): <input type="checkbox"/> Married <input type="checkbox"/> Married but living apart <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single Living with Partner <input type="checkbox"/> Single	Type of medical insurance for <u>each applicant</u>: <input type="checkbox"/> Blue Plus <input type="checkbox"/> Ucare <input type="checkbox"/> None <input type="checkbox"/> Other _____
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Mother/Guardian-Employment status: (Check all that apply) <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal/On-Call <input type="checkbox"/> Retired/Disabled <input type="checkbox"/> Training or School <input type="checkbox"/> Military <input type="checkbox"/> Unemployed: Date Last Worked: _____ Name of employer(s) _____ Date started: _____	Father/Guardian-Employment status: (Check all that apply) <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal/On-Call <input type="checkbox"/> Retired/Disabled <input type="checkbox"/> Training or School <input type="checkbox"/> Military <input type="checkbox"/> Unemployed: Date Last Worked: _____ Name of employer(s) _____ Date Started: _____
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Mother/Guardian-Highest level of Education: <input type="checkbox"/> High School Diploma/GED <input type="checkbox"/> Associates <input type="checkbox"/> Bachelors <input type="checkbox"/> No Education <input type="checkbox"/> Completed Grade _____ <input type="checkbox"/> Masters or higher	Father/Guardian-Highest level of Education: <input type="checkbox"/> High School Diploma/GED <input type="checkbox"/> Associates <input type="checkbox"/> Bachelors <input type="checkbox"/> No Education <input type="checkbox"/> Completed Grade _____ <input type="checkbox"/> Masters or higher
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Fill out all information for EACH person living in your home. Please print clearly.
EHS = Early Head Start (for infants and toddlers up to age 3 who are enrolled in participating childcare centers)

FIRST NAME	LAST NAME	BIRTH DATE	SEX	RACE <small>(use code below)</small>	ETHNICITY <small>(Circle ONE)</small>	RELATIONSHIP TO YOU	RELATIONSHIP TO OTHER PARENT	Applicants only— circle program 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
4.		/ /	M F		Hispanic Non Hispanic			EHS
5.		/ /	M F		Hispanic Non Hispanic			EHS
6.		/ /	M F		Hispanic Non Hispanic			EHS
7.		/ /	M F		Hispanic Non Hispanic			EHS
8.		/ /	M F		Hispanic Non Hispanic			EHS
9.		/ /	M F		Hispanic Non Hispanic			EHS

ENTER CODE FOR **RACE**: 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

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 RECEIVES.
PROOF OF ALL INCOME IS REQUIRED WITH YOUR APPLICATION (right box) TO DETERMINE ELIGIBILITY**

<p>Check any of the following your family receives:</p> <p><input type="checkbox"/> MFIP (cash only)</p> <p><input type="checkbox"/> Child Care Assistance</p> <p><input type="checkbox"/> SSI (Supplemental Security Income)</p> <p><input type="checkbox"/> DWP (Diversionary Work Program)</p> <p><input type="checkbox"/> Refugee Match Grant</p> <p><input type="checkbox"/> None of these</p> <p>From what County do you receive these from? _____</p>	<p>Please answer the following:</p> <p>Total monthly income before taxes: \$ _____</p> <p>Does anyone in your family receive child support? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, what county? _____</p> <p>Has anyone filed for child support? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, what County? _____</p> <p>Who has custody of the child applicant(s)? _____</p> <p>Has anyone received Financial Aid Grants or any Scholarships in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has anyone received payments from Unemployment, Workers Comp, or Social Security in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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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) _____

Name of childcare center that your child attends: _____

What days of the week does your child attend? Monday Tuesday Wednesday Thursday Friday

Hours that your child attends childcare: _____

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	Rice County Public Health	Friends or Family
Early Childhood Screening	Health Care Provider	Other (please specify)

For the Early Head Start Partnership – I am giving permission to exchange my child/family information which may include health, school, work, attendance, parent share, developmental and enrollment information with the early childhood program my child may or currently attends.

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. **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