

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.

Applications also available at www.familiesfirstmn.org.

Mail to: Families First Head Start

126 Woodlake DR SE, Rochester, MN 55904

Or drop off at: Brookside Education Center, Head Start Office, office hours Monday through Friday 8 a.m. to 4:30 p.m.

Email Proof of income to: andreap@familiesfirstmn.org

Please keep this page for your reference.

Income qualifying 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.

Early Head Start is:

- **For pregnant mothers infants and toddlers under 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, 2019**
- 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



"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, 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		Cell Phone Number		
Zip Code							
Name of Person if we cannot contact you: _____				Your Email Address (please print clearly): _____			
Phone Number : _____							
Do you speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No		Language spoken at home _____		Can you drive your child to and from school if a bus is not available? <input type="checkbox"/> Yes <input type="checkbox"/> No			
How well? None Little Average Very Well		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 _____			
Do you want to apply for Early Head Start Services as a pregnant mother? <input type="checkbox"/> Yes <input type="checkbox"/> No				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 _____			
Parent/Guardian 1 -Employment status: (Check all that apply) <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal/On-Call Name of employer(s) _____ Date Started: _____ <input type="checkbox"/> Retired/Disabled <input type="checkbox"/> Training or School <input type="checkbox"/> Military <input type="checkbox"/> Unemployed: Date Last Worked: _____				Parent/Guardian 2 -Employment status: (Check all that apply) <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal/On-Call Name of employer(s) _____ Date Started: _____ <input type="checkbox"/> Retired/Disabled <input type="checkbox"/> Training or School <input type="checkbox"/> Military <input type="checkbox"/> Unemployed: Date Last Worked: _____			
Parent/Guardian 1 -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				Parent/Guardian 2 -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			
Fill out all information for EACH person living in your home. Please print clearly. CIRCLE the program each applicant is applying for. Programs you can apply for: EHS = Early Head Start (for pregnant mothers and children under age 3) HS = Head Start (HS is for children age 3 or 4 on or before Sept. 1, 2019)							
FIRST NAME	LAST NAME	BIRTH DATE	SEX	RACE (use code below)	ETHNICITY (Circle <u>ONE</u>)	RELATIONSHIP TO APPLICANT(S)	Applicants only— circle ALL program(s) applying for:
Parent/Guardian 1 from above (if living in home)		/ /	M F		Hispanic Non Hispanic		
Parent/Guardian 2 from above (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 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.

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

2018 INCOME IS REQUIRED WITH YOUR APPLICATION TO DETERMINE ELIGIBILITY. QUESTIONS ON INCOME CALL: 507-287-2009

Check any of the following your family received within the last 6 months:

- MFIP CASH
- 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 hardship	Home in foreclosure or getting evicted. Eviction date: _____
Staying at a shelter or Transitional Housing	Other (please explain) _____

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:

For families with children Under 3

I am interested in the weekly home visit program. Yes No

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

My applicant child _____ has completed an Early Childhood Screening at _____ on _____.
 (Name) (School District/location) (Date)

I give permission to exchange information with Early Childhood Screening. **I give permission** to Families First of Minnesota, Head Start to verify any county public assistance and/or child support that I may receive. **I give permission** to exchange my child/family information which may include health, school, work, attendance, parent share, developmental and enrollment information with my Early Childhood Programs.

To the best of my knowledge the information I have given is accurate and true. Authorization is valid for one calendar year from the date it is signed.

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