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: anitah@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 by phone or email. Please tell us if your phone number or address changes. We accept applications year round.

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, 2022**
- 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 in other languages or have any questions, call us at:

507-287-2009 Or 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 FAMILIES FIRST OF MINNESOTA, INC.

EARLY HEAD START AND HEAD START

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	City	State	Zip Code	Parent/Guardian 1 Phone Number
Mailing Address if different than home address				Parent/Guardian 2 Phone Number

Name of Person if we cannot contact you: ___________________________

Phone Number :____________________________________ _____________

Your Email Address *(please print clearly)*: ____

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** ____________________

Parent/Guardian 1 -Employment status: (Check all that apply)

☐ Full Time ☐ Part Time ☐ Seasonal/On-Call

Name of employer(s)_________________**Date Started**:____________

☐ Retired/Disabled ☐ Training or School ☐ Military

☐ If Unemployed date last worked: ____________________________

Parent/Guardian 2 -Employment status: (Check all that apply)

☐ Full Time ☐ Part Time ☐ Seasonal/On-Call

Name of employer(s)_________________**Date Started**:____________

☐ Retired/Disabled ☐ Training or School ☐ Military

☐ If Unemployed date last worked: ____________________________

<u>Parent/Guardian 1 -Highest level of Education</u>:

☐ High School Diploma/GED ☐ Associates ☐ Bachelors

☐ No Education ☐ Completed Grade ______ ☐ Masters or higher

<u>Parent/Guardian 2 -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 under age 3)

HS = Head Start (HS is for children age 3 or 4 on or before Sept. 1, 2022)

FIRST NAME	LAST NAME	BIRTH DATE	SEX	RACE (use code below)	ETHNICITY (Circle <u>ONE)</u>	RELATIONSHIP TO APPLICANT(S)	Applicants only—circle <u>ALL</u> 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

ENTER CODE FOR **<u>RACE</u>**:

NA/AN= American Indian / Alaska Native A = Asian B = Black or African American NH/PI = Native Hawaiian / 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.		
	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**

2021 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 Assistance)
- ☐ SNAP (Food Benefits)
- ☐ WIC
- ☐ Cash Assistance from another state
- ☐ Child Care Assistance
- ☐ SSI (Supplemental Security Income)
- ☐ DWP (Diversionary Work Program)
- ☐ Refugee Match Grant

From what County? _________________________

Please answer the following:

Total monthly income before taxes: $______________

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

Has anyone received payments from either of these sources in the last year?

___Unemployment: Name ______________________________________

___Social Security: Name ______________________________________

	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

I would like my child to attend child care while I go to work or school. ☐ Yes ☐ No

-If yes, children's center ☐ Main site ☐ St. John's Site

-If choosing this option, **you must apply for Child Care Assistance .**

Please Apply online at mnbenefits.mn.gov.

	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 Families First of MN partner 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