

West River Head Start Application



Age requirement: 3 – 5 years old. A child is age-eligible on his/her 3rd birthday...even during the school year! Kindergarten-age children cannot enroll in Head Start.

Classroom Hours: Children attend Monday-Thursday: Mandan 3 classes 8AM-2PM and 1 class 7:30-3:30, Carson 8AM-4PM, Hazen 8AM-4PM, New Salem 7:30AM-3:30PM CT.

There is no charge to the families who participate in this program. We provide services to children who live in Morton, Oliver, Grant and Mercer counties with classrooms in Mandan, New Salem, Carson & Hazen.

Submit the following documents with the application to determine your child's eligibility.

★ **Verification of Income**

- 2020 tax return; OR
- Current pay stubs; OR
- Proof of: TANF, SSI, Foster Care; OR
- Homelessness or No Income (forms are attached)

If your income decreases, submit updated verification.

★ **Verification of Child Support** If applicable.

★ **Child's Birth Certificate** or official proof child's date of birth

★ **Immunization Record**

★ **Medicaid Card Or Health Insurance Card**



2021 Income Guidelines

Persons in Family	100% Poverty	130% Poverty
2	\$ 17,420	\$ 22,646
3	\$ 21,960	\$ 28,548
4	\$ 26,500	\$ 34,450
5	\$ 31,040	\$ 40,352
6	\$ 35,580	\$ 46,254
7	\$ 40,120	\$ 52,156
8	\$ 44,660	\$ 58,058
	<i>For each additional person, add \$4,540</i>	<i>For each additional person, add \$5,902</i>

Head Start is a federally funded program. Eligible families receive priority.

A LOOK AHEAD...

After you have been notified that your child will be attending Head Start, set up appointments for the **Well Child Exam OR Health Tracks Screening** and **Dental Exam**. If your child has had an exam in the last 12 months, have the provider complete the West River Head Start form.

★ **Well Child Exam / Health Tracks Screening** If you are Medicaid eligible, you qualify for Health Tracks Screening through Custer Health. Health Tracks Screenings are scheduled through Social Services.

- Grant County (701) 622-3706
- Morton County (701) 667-3395
- Mercer County (701) 745-3384
- Oliver County (701) 794-3212

★ **Dental Exam** Schedule with your family dentist.



Our Contact Information

1004 7 th St SW Mandan, ND 58554 Tel (701)663-9507 Fax (701)663-9643 MAIN OFFICE	210 2 nd Ave West PO Box 197 Carson, ND 58529 (701)622-3505 Fax (701)622-3236	519 1 st Ave NE PO Box 487 Hazen, ND 58545 Tel (701)748-3736 Fax: please call for info	400 N 4 th Street PO Box 116 New Salem, ND 58563 Tel (701)843-8061 Fax: please call for info
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Date Received: _____

West River Head Start Application

Assurance of confidentiality: This information is being requested on a voluntary basis. The information will help us determine the services most appropriate to meet your family's needs. Some information may be used to help guide national programming. If you choose not to provide some of the information, it will not affect your child's services. However, some information is required to determine if your child is eligible for the program. All information will be held in strict confidence.

Child to Enroll					
First	Middle	Last	Suffix	Birthday	Gender
					<input type="checkbox"/> Male <input type="checkbox"/> Female
Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
<input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Proficient <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> None		<input type="checkbox"/> Proficient <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> None
Medical Insurance		Medicaid Eligibility	Medicaid #	Doctor/Medical Home	
		<input type="checkbox"/> Not Eligible <input type="checkbox"/> On Medicaid <input type="checkbox"/> Potentially			
Dental Coverage		Dental Coverage #		Dentist/Dental Home	
Has the child been identified as having, or is suspected of having, any of the following? <i>Mark all that apply.</i>				<input type="checkbox"/> <i>Parent report indicates no disabilities.</i>	
<input type="checkbox"/> Autism <input type="checkbox"/> Emotional/behavioral disorder <input type="checkbox"/> Health impairment <input type="checkbox"/> Hearing impairment <input type="checkbox"/> Learning disability <input type="checkbox"/> Orthopedic impairment <input type="checkbox"/> Speech or language impairment <input type="checkbox"/> Traumatic brain injury <input type="checkbox"/> Visual impairment (including blindness)		Other impairments (please list):		<i>Is your child on an Individualized Education Plan (IEP)?</i> <input type="checkbox"/> yes <input type="checkbox"/> no If you answered yes: <input type="checkbox"/> Speech/Language Delay <input type="checkbox"/> Non-categorical Delay <input type="checkbox"/> Other: _____	

Child to Enroll Address						
Living Address		Zip	City	State	County	
Mailing Address (if different from living address)		Zip	City	State		
Parental Status <i>(check one)</i>	Primary Language at Home	Homeless Family	Active Duty Military	Referred by Child Welfare Agency	Receiving SNAP	WIC
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Parent / Guardian #1 Information						
First	Middle	Last	Suffix	Birthday	Gender	
					<input type="checkbox"/> Male <input type="checkbox"/> Female	
Race		Hispanic	English Proficiency	Other Language		
<input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Proficient <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> None			
Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:
<input type="checkbox"/> HS Graduate <input type="checkbox"/> GED <input type="checkbox"/> Some college <input type="checkbox"/> Associate's <input type="checkbox"/> Bachelor's <input type="checkbox"/> Master's <input type="checkbox"/> Doctorate		<input type="checkbox"/> Highest grade level completed: _____ <input type="checkbox"/> Full Time <input type="checkbox"/> Training or School <input type="checkbox"/> Part Time <input type="checkbox"/> Retired or Disabled <input type="checkbox"/> Seasonal <input type="checkbox"/> Unemployed		<input type="checkbox"/> Biological/Adopted/Step <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Relative <input type="checkbox"/> Foster <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lives with child <input type="checkbox"/> All the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Never
Place of Employment		How often do you get paid?		Email Address		
		<input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Other: _____				

Parent / Guardian #1 Information (continued)

Living Address	Zip	City	State	County
Mailing Address (if different from living address)	Zip	City	State	County
Phone Number(s)	Type (check one)			Opt In for Text Messages
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other			<input type="checkbox"/> Yes <input type="checkbox"/> No

Parent / Guardian #2 Information

First	Middle	Last	Suffix	Birthday	Gender
					<input type="checkbox"/> Male <input type="checkbox"/> Female
Race		Hispanic	English Proficiency	Other Language	
<input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Proficient <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> None		
Highest Grade Completed		Employment Status		Child's Relationship	Custody
<input type="checkbox"/> HS Graduate <input type="checkbox"/> GED <input type="checkbox"/> Some college <input type="checkbox"/> Associate's <input type="checkbox"/> Bachelor's <input type="checkbox"/> Master's <input type="checkbox"/> Doctorate	<input type="checkbox"/> Highest grade level completed: _____	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal	<input type="checkbox"/> Training or School <input type="checkbox"/> Retired or Disabled <input type="checkbox"/> Unemployed	<input type="checkbox"/> Biological/Adopted/Step <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Relative <input type="checkbox"/> Foster <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
Check all that apply:					
<input type="checkbox"/> Lives with child <input type="checkbox"/> All the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Never					
Place of Employment		How often do you get paid?		Email Address	
		<input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Other: _____			
Living Address	Zip	City	State	County	
Mailing Address (if different from living address)	Zip	City	State	County	
Phone Number(s)	Type (check one)			Opt In for Text Messages	
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other			<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other			<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other			<input type="checkbox"/> Yes <input type="checkbox"/> No	

List all other children who live in the home.

Child #1					
First	Middle	Last	Suffix	Birthday	Gender
					<input type="checkbox"/> Male <input type="checkbox"/> Female
Race		Hispanic	English Proficiency	Relationship to Child Applicant	Lives with the Child Applicant
<input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Proficient <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> None	<input type="checkbox"/> Sibling <input type="checkbox"/> Step-sibling <input type="checkbox"/> No biological/legal relationship	<input type="checkbox"/> All of the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Never	

Child #2					
First	Middle	Last	Suffix	Birthday	Gender
					<input type="checkbox"/> Male <input type="checkbox"/> Female
Race		Hispanic	English Proficiency	Relationship to Child Applicant	Lives with the Child Applicant
<input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Proficient <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> None	<input type="checkbox"/> Sibling <input type="checkbox"/> Step-sibling <input type="checkbox"/> No biological/legal relationship	<input type="checkbox"/> All of the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Never	

Child #3					
First	Middle	Last	Suffix	Birthday	Gender
					<input type="checkbox"/> Male <input type="checkbox"/> Female
Race		Hispanic	English Proficiency	Relationship to Child Applicant	Lives with the Child Applicant
<input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Proficient <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> None	<input type="checkbox"/> Sibling <input type="checkbox"/> Step-sibling <input type="checkbox"/> No biological/legal relationship	<input type="checkbox"/> All of the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Never	

Child #4					
First	Middle	Last	Suffix	Birthday	Gender
					<input type="checkbox"/> Male <input type="checkbox"/> Female
Race		Hispanic	English Proficiency	Relationship to Child Applicant	Lives with the Child Applicant
<input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Proficient <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> None	<input type="checkbox"/> Sibling <input type="checkbox"/> Step-sibling <input type="checkbox"/> No biological/legal relationship	<input type="checkbox"/> All of the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Never	

Child #5					
First	Middle	Last	Suffix	Birthday	Gender
					<input type="checkbox"/> Male <input type="checkbox"/> Female
Race		Hispanic	English Proficiency	Relationship to Child Applicant	Lives with the Child Applicant
<input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Proficient <input type="checkbox"/> Moderate <input type="checkbox"/> Little <input type="checkbox"/> None	<input type="checkbox"/> Sibling <input type="checkbox"/> Step-sibling <input type="checkbox"/> No biological/legal relationship	<input type="checkbox"/> All of the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Never	

** If you are applying for multiple children, please complete a separate copy of this form for each applicant.*

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.*

Parent/Guardian Signature _____ Date _____

West River Head Start
Eligibility Document: Family / Individual Claiming Zero Income

Complete only if you have no income.

NOTE: Child support is considered income. If you are receiving child support, submit documentation to show how much you are receiving instead of completing this form.

Explain how you are meeting your family's basic needs.

How are you providing clothing for your family?
How are you covering the cost of housing?
How are you providing for food for your family?
Describe your living situation.

I give permission for West River Head Start to contact a someone else to verify this information. My third party contact is (NOT YOUR OWN NAME):

Name: _____ Relationship/title: _____ Phone #: _____

Signature of parent	Date
Staff signature	Date
Staff signature	Date

**This side is to be completed by
WEST RIVER HEAD START STAFF**

Third Party Zero Income Verification Notes:

1. What is your relationship with the applicant?

2. How long have you known them?

3. Explain what you know about their situation.

4. Can you verify there is zero income?

Homeless Verification Form

Complete only if you are homeless.

Subtitle B of the Title VII of the McKinney-Vento Homeless Assistance Act (and the Improving Head Start for School Readiness Act of 2007) defines "homeless" as follows:

- Individuals who lack a fixed, regular, and adequate nighttime residence;
- Children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason;
- Children and youths who are living in motels, hotels, trailer parks or camping grounds due to the lack of alternative adequate accommodations;
- Children and youths who are living in emergency or transitional shelters;
- Children and youths who are abandoned in hospitals;
- Children and youths who are awaiting foster care placement;
- Children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;
- Children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings;
- Migratory children who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described above.

I give permission for West River Head Start to contact someone else to verify this information. My third party contact is (NOT YOUR OWN NAME):

Name: _____ Relationship/title: _____ Phone #: _____

Signature of parent / guardian / adult verifying initial statement	Date
Staff Signature	Date
Staff Signature	Date

**This side is to be completed by
WEST RIVER HEAD START STAFF**

Third Party Homeless Verification Notes:

1. What is your relationship with the applicant?

2. Can you explain what you know about their situation?

3. Can you verify that they are homeless?