Ogden Weber Community Action Partnership
Head Start/Early Head Start Program

Dear Parent/Guardian,

OWCAP Head Start/Early Head Start is a School Readiness program for all children in need, living in Weber County.

Early Head Start is for children under the age of 3. We offer a home based program and a teen program that provides care for children while the parent is attending school or working.

Head Start is for children ages 3 & 4 by September 1st. We offer various Head Start options.

The program is **free** for children and families accepted into these program. The Ogden-Weber Community Action Partnership, Inc. (OWCAP) Head Start has been providing quality services to children and families in Weber County since 1965.OWCAP Head Start has caring and highly qualified staff and provides educational, health, and family services for your child and family.

Please be aware that you will have to provide or plan for transportation services for your child to and from school. Assistance with transportation may be provided when circumstances warrant.

Please read thoroughly and complete the application. Refer to our website, our Facebook page or call for registration dates. **Please bring all listed documents and application to registration.**

Thank you for your interest in Head Start/Early Head Start.

United Way of Northern Utah

OWCAP Head Start/Early Head Start Application Checklist

PLEASE NOTE THAT IF THE ITEMS LISTED BELOW ARE NOT PRESENTED AT YOUR REGISTRATION, WE WILL BE UNABLE TO KEEP AND PROCESS YOUR APPLICATION.

When you come to registration, PLEASE have the application and the following items with you:

- o **BIRTH CERTIFICATE** (or other proof of birth) must include: child's name, birth date, and parent's names.
- o **INCOME VERIFICATIONS** Please bring proof of your income for the past 12 months. Please let your Family Service Worker know of periods of unemployment.

  INCOME VERIFICATIONS (which together must reflect a full year of income — may include):
  - Tax Form 1040's
  - Last year's W-2 forms
  - Current financial assistance income printout from DWS
  - Social Security Letter (reflecting amount of income)
  - Employer Letter (last year income total)
  - Check stubs (must cover last year's total income)
  - Proof of Foster Placement or State Custody Letter from DCFS

- o **PROOF OF PUBLIC ASSISTANCE** (SSI, TANF/FEP, dated within 90 days)
- o **PROOF OF RESIDENCY IN WEBER COUNTY** (Examples: utility bill, Picture ID., etc.)
- o **OFFICIAL SHOT RECORDS** (Immunizations are available at low or no cost at Weber Health Department 477 23rd Street)
- o **INSURANCE CARD** (**If you have** private insurance- Medicaid, IHC, Chip, etc.)

Other items that are needed if your child is accepted:

- o **A PHYSICAL** (to include Blood Pressure, Hemoglobin, and Lead Test)
- o **DENTAL EXAM** (to include cleaning and / or fluoride application)

Head Start welcomes all **foster** children. Please attach a copy of your child's DCFS custody letter to the application.

Children with **disabilities or special needs** are welcome. Please attach a copy of your child's IEP or IFSP to the application.

Where do I find more information about OWCAP and Head Start/Early Head Start?

www. owcap.org
www.eclkc.ohs.acf.hhs.gov/hslc
801.399.9281
Facebook: http://www.facebook.com/Ogden-Weber CAP Head Start

Frequently Asked Questions

Once I complete and turn in my child's application what will happen next?
Upon receiving your application, the Family Service Worker will give you a letter stating whether your child is eligible, moderate or over-income. Your child will then be placed on the eligible, moderate, or over-income waitlist for the appropriate site and option, as determined by OWCAP boundaries. OWCAP begins the selection process in June for the up-coming year. Children are accepted by a point system, meaning neediest children with the highest points and need are accepted first.

Does my child need to be potty trained to attend Head Start?
No, our teachers are trained to work with children and the parent to help potty train them.

When will I hear if my child is in the program?
Letters are sent to families who have been accepted into the program the first week of September. If your child is not accepted, your child will remain on the waitlist until there is an opening. The selection committee meets regularly. **You will be called** by a Family Service Worker or Teacher **IF** your child is accepted. Your child's application will remain active through the program year.

What if I move after I submit my application?
It is important to notify OWCAP as soon as possible when there is a change in address and/or phone number. Please call us at 801.399.9281 to update your new phone number and, if applicable, your child's new address. We will also need a new address verification such as a bill, rental agreement, etc. that shows your new address. **This can be dropped off at 3159 Grant Ave, Ogden**.

Will my child get into the program?
If your child is **age and income eligible,** your chances are very good; **but we cannot guarantee your child will get in. We have a waiting list every year!** The program **IS NOT** first-come first-served, but the sooner you turn in your application the better. We encourage you to have your application turned in by June. Government regulations require service to **those in the community who need the services the most**. Therefore, each application is rated based on the information provided in the application.

Is there an attendance requirement for my child to attend Head Start/Early Head Start?
It is critical that you arrange, in advance, how your child will get to and from Head Start/Early Head Start. Attendance affects your child's learning and starts good habits for future school experiences. The Office of Head Start has an expectation that children do not miss more than 1 day a month.

How much does Head Start/Early Head Start cost?
Head Start/Early Head Start is a free program; there is no cost to parents for any services, **unless you attend the full-day child care location.** (Contact the State Childcare (DWS) if you need childcare assistance.)

What is the Home Base Program?
The Home Base Program is a weekly visit in your home for 1.5 hours, there are also 2 play groups each month for 2 hours.

Registration to be held at:
Ogden-Weber Community Action Partnership
3159 Grant Avenue
Ogden, UT 84401
Call
(801) 399-9281

For Registration dates & times or to schedule an appointment.
www.owcap.org
https://www.facebook.com/OWCAP.UT/ CAP Head Start

Family Service Worker Contact:

Name: _____

Phone Number: _____

Notes: _____

_____

❑HS
❑EHS

Family Member Information

Shaded boxes will be completed by agency staff.

CHILDPLUS

Primary Adult Name _____ Birthday_____

Applicant Name (child) _____ Birthday_____

Primary Adult (nonparticipant) Living in the Household

Last | First | Middle | Preferred

Birthday | Gender | ❑ Provides Financial Support | ❑ Teen Parent

Highest Grade Completed _____

Graduated High School ❑ Yes ❑ No

Employment Status [1]

Email Address

English Proficiency: ☐ Primary Language

❑ None ❑ Poor ❑ Moderate ❑ Proficient

Currently Attending School or In Job Training? ❑Yes ❑No

Current Teen Parent? (Under 19) ❑Yes ❑No

Secondary Adult (nonparticipant) Living in the Household

Are you related to the child by blood, marriage, adoption, have court-ordered custody, or authorized care giver? ❑Yes ❑No

Last | First | Middle | Preferred

Birthday | Gender | ☐ Lives with Child | ☐ Provides Financial Support

Highest Grade Completed _____

Graduated High School ❑ Yes ❑ No

Employment Status [1]

Email Address

English Proficiency: ☐ Primary Language

❑ None ❑ Poor ❑ Moderate ❑ Proficient

Currently Attending School or In Job Training? ❑Yes ❑No

Current Teen Parent? (Under 19) ❑Yes ❑No

[1] F**- Full Time,** P **- Part Time,** R **- Retired or Disabled,** T **- Training or School,** S **- Seasonally Employed,** U **- Unemployed**

Child Applying for Head Start

Last | First | Middle | Preferred

Birthday | Gender

Race (*check all that apply*)
☐ Asian ☐ Native American
☐ Black ☐ Pacific Islander
☐ White ☐ Other _____

Ethnicity
☐ Hispanic
☐ Non-Hispanic

Nationality
Country where child was born: _____

English Proficiency: ☐ Primary Language

❑ None ❑ Poor ❑ Moderate ❑ Proficient

Other Language Spoken _____

☐ Poor ☐ Moderate ☐ Proficient

C-Natural/Adopted/Step **G**-Grandchild **N**-Niece/Nephew **F**-Foster **O**-Other

Choose from list Above

Primary Adult Relationship: _____
Custody: Yes ☐ No ☐

Secondary Adult Relationship: _____
Custody: Yes ☐ No ☐

❑ Medicaid Eligibility: Medicaid Number _____

❑ Private Insurance Coverage: Insurance Number _____

❑ Dental Insurance Dental Insurance No. _____

Doctor/Dentist (of applying child)

Doctor Name | Address | City | State | Zip | Phone

Dentist Name | Address | City | State | Zip | Phone

Is there a person in the **immediate** family living in a correctional facility? ❑Yes ❑No

Relationship to the child: : _____

Siblings of applying child

Last	First	Birthday	Gender

Family Information

Shaded boxes will be completed by agency staff.

Applicant Name _____ Birthday _____

General Information

Living Address	City	State	Zip
Mailing Address (if different)	**City**	**State**	**Zip**

Phone Number	Home, Work, Cell, etc.	Primary	Receive Text Messages	Notes
		☐	☐ Yes	
		☐	☐ Yes	
		☐	☐ Yes	

Do you lack a fixed, regular, and adequate night time residence? ❒ Yes ❒ No	Are you sharing the housing of other persons due to loss of your own housing, your own economic hardship, or a similar reason? ❒ Yes ❒ No	Which of the situations below apply to the child? Living in: ❒ a motel ❒ Hotel ❒ trailer park ❒ Campground ❒ Emergency or transitional shelter ❒ Abandoned in hospital ❒ Awaiting foster care placement	❒ Primary Nighttime Residence is a public or private space not designed for sleeping accommodations ❒ Migrant Child	Living in: ❒ Car ❒ Park ❒ Public spaces ❒ Abandoned building ❒ Substandard Housing ❒ Bus or train station

Primary Site	Parental Status ☐One ☐Two	Primary Language at Home

Family Information (To be completed by staff)

☐**SSI** ☐ **WIC** ☐**TANF/FEP**

At least one parent or guardian is a member of the US Military? ❒ **Yes** ❒ **No** **At least one or parent/guardian is a veteran of the US Military?** ❒ **Yes** ❒ **No**	**Receiving supplemental nutrition assistance program (SNAP) (food Stamps)** ❒ **Yes** ❒ **No**

Amount	Per	Annual Amount	Description	Verification	Note

		Verification Codes **CS**–Check Stub **W2**–W-2 **EL**–Employer Letter **TX**–Taxes

Income Notes

Contacts

It is very important that we have *complete* information in case of an emergency!!
Please inform these people that you have added them as a contact for Head Start purposes. These are the only people who will be allowed to pick up your child in addition to the parent/guardians.

Emergency Contacts (Not Primary or Secondary Adults)

Phone Type Codes: **H**-Home **W**-Work **C**-Cell **M**-Message

Contact 1	Name		Phone Type	Phone Number	Phone Note	Relationship to Child
	Address			( )		
				( )		Emergency Contact? Yes No
	City			( )		Release To? Yes No
	State	Zip		( )		
Contact 2	Name		Phone Type	Phone Number	Phone Note	Relationship to Child
	Address			( )		
				( )		Emergency Contact? Yes No
	City			( )		Release To? Yes No
	State	Zip		( )		
Contact 3	Name		Phone Type	Phone Number	Phone Note	Relationship to Child
	Address			( )		
				( )		Emergency Contact? Yes No
	City			( )		Release To? Yes No
	State	Zip		( )		
Contact 4	Name		Phone Type	Phone Number	Phone Note	Relationship to Child
	Address			( )		
				( )		Emergency Contact? Yes No
	City			( )		Release To? Yes No
	State	Zip		( )		
Contact 5	Name		Phone Type	Phone Number	Phone Note	Relationship to Child
	Address			( )		
				( )		Emergency Contact? Yes No
	City			( )		Release To? Yes No
	State	Zip		( )		

Enrollment Information

Applicant Name _____ Birthday _____

CHILDPLUS

Transportation

Address where the child is located during Head Start operating hours (we want to provide services at the closest Head Start facility).

Address:

Releases Signed? ❑ Yes ❑ No	Date Signed

Do you suspect your child has a disability?

❑ Yes ❑ No ❑ Diagnosed If yes, what is the suspect or diagnosed disability? _____

Does your child have a current Individualized Education Plan (IEP) or IFSP? ❑ Yes ❑ No (Please provide copy)

With whom? _____

At which Elementary School will your child attend kindergarten?

Primary Site:	Other Sites I am willing to transport to: ❑ All Sites			
	❑ Your Community Connection ❑ South Ogden ❑ James Madison	❑ OWCAP ❑ Green Acres ❑ Gramercy	❑ OWATC-N ❑ Country View	❑ Marshall White ❑ North Park

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 _____

Verifying Staff Member _____ Date _____

To be completed by agency staff.

Program Details

Program/Term	Site	Application Status [1]	Application Number

Enrollment

Application Date	Eligibility Notes

Eligibility

Eligibility Income	Num in Family	Income Status [2]	Participation Year	❑ Child Elig Next Year ❑ Sibling Elig Next Year	Class Age

		Points
Child Status		
Parental Status		
Disability		
Income		
Age		
Criterion 1		
Criterion 2		
Criterion 3		
Criterion 4		
Criterion 5		
Criterion 6		
	Total	

1. Application Status Codes
C-Complete & Verified
M-Complete, Needs Medical Info

2. Income Status Codes
E-Eligible H-Homeless M-Moderate
F-Foster Child P-Public Asst **O**-Over Income

Is this child income eligible for Head Start? ☐Yes ☐No

Ogden-Weber Community Action Partnership Head Start

Head Start / Early Head Start Permission / Consent Form

(Please mark each question with a yes or no)

Child's Name:_____ Birth Date: _____

The granting of consent is voluntary on the part of the parent and may be revoked at any time. If a parent revokes consent this action is not retroactive and therefore does not apply to an action that occurred before the consent was revoked.

OWCAP will share child's record to include immunization, birth and health information with the school district or school identified by parent in which the child seeks or intends to enroll. As the parent you have an opportunity to challenge and refuse disclosure of the information in the records.

OWCAP takes and uses photographs and videos of your child for both educational and promotional purposes. If you would like to opt out please notify staff.

I give my permission/consent for Head Start to:

1. Share and receive information (screenings, classroom observation) with the School Districts or LEA on my child's education, special needs and IEP/IFSP. ❒ Yes ❒ No
2. Share and receive child & family records with other agencies or organizations that provides support or services to you and your family. (If you mark yes, please list agency, i.e. WIC, DWS, DCFS, etc.) ❒ Yes ❒ No
   List Agency: _____
3. Conduct screenings and assessments:
   A. ❒Yes ❒No Physical
   B. ❒Yes ❒No Blood Pressure
   C. ❒Yes ❒No Hematocrit/hemoglobin (possible finger poke)
   D. ❒Yes ❒No Growth Assessment
   E. ❒Yes ❒No Lead Screening (done by pricking child's finger)
   F. ❒Yes ❒No Dental
   G. ❒Yes ❒No Mental Health consultation services
   H. ❒Yes ❒No Hearing
   I. ❒Yes ❒No Vision
   J. ❒Yes ❒No Behavioral
   K. ❒Yes ❒No Developmental
   L. ❒Yes ❒No Speech
   M. ❒Yes ❒No Autism (Early Head Start only)
   N. ❒Yes ❒No Nutrition Screening
4. Take my child on field trips and participate in special activities on or off site. ❒ Yes ❒ No
5. Transport my child when necessary, with prior consent. ❒ Yes ❒ No

I give my permission/consent for:

6. My child to receive fluoride varnish provided by Head Start. ❒ Yes ❒ No
   (**IMPORTANT:** Fluoride varnishes will be applied every six months)
7. I give permission to any dentist or clinic to release information on my child to the Head Start program. ❒ Yes ❒ No
8. I give permission to any doctor or clinic to release information on my child to the Head Start program. ❒ Yes ❒ No
9. I am interested in the:
   A. ❒Yes ❒No OWCAP/WSU in-home Family Literacy Project
   B. ❒Yes ❒No Serving on the OWCAP Head Start Policy Council (similar to school PTA)
   C. ❒Yes ❒No Serving on the Fatherhood Committee (Father/Father Figures Only)
11. How did you hear about Head Start?
    ❒Family, friends, word of mouth
    ❒Mail or flyer left at my home
    ❒Poster or flyer: Where? _____
    ❒ Community Agency (name):_____
    ❒Fair or event (name/location):_____
    ❒Other: _____
12. What is your preferred language? (Which language would you like Head Start staff to communicate with you?)

    _____

I hereby release the Ogden-Weber Community Action Head Start Program from any and all liability on the information above.

_____ _____
Parent/Guardian Signature Date

Nutrition Assessment & Child Health History

Child's Name: _____ DOB:_____ Gender: _____Class: _____

Food allergies:
Does your child have any allergies and/or intolerances that have been verified by a physician? ❒ Yes ❒ No
If yes please list: _____
Please bring documentation from your child's physician regarding the allergies you have listed.

Special dietary needs:
Does your child have special dietary requirements (cultural, religious, eating patterns, specialized formula, other personal food preferences, or medical dietary needs)? _____

Please check all that apply to your child:

- ❒ Anemia
- ❒ Malnutrition
- ❒ Swallowing difficulties
- ❒ Picky/under/over-eating
- ❒ Frequent constipation
- ❒ Tube feeding
- ❒ Vitamin and/or mineral deficiencies
- ❒ Sensorial accommodations
- ❒ Feeding concerns
- ❒ Chewing difficulties
- ❒ Diabetes
- ❒ Overweight
- ❒ Underweight
- ❒ Breastfeeding
- ❒ Other _____

Do you have any concerns related to your child's growth? □ Yes □ No
Do you have any other concerns about your child's nutrition status and/or eating habits? □ Yes □ No
If yes, please list your concerns: _____

Are you interested in speaking to our Registered Dietitian about any of the above nutrition and feeding topics?
❒ Yes ❒ No (*If yes, please complete an in-house referral to the Nutrition Supervisor.)*

Please check all that apply to your child:

- ❒ Ear infections
- ❒ Seizures
- ❒ Birth defects
- ❒ Heart defects
- ❒ Frequent diarrhea/constipation
- ❒ Vision problems/glasses
- ❒ Asthma
- ❒ Frequent colds/coughs
- ❒ Hearing Problems/Aids
- ❒ Bone, joint, and muscle deformity
- ❒ Seasonal allergies
- ❒ Allergies to insects/bee stings
- ❒ Eczema/skin irritation
- ❒ Serious Injuries_____
- ❒ Other (physical and/or behavioral)_____

Does your child use an inhaler and/or nebulizer? ❒ Yes ❒ No
Does your child have other medication that is needed in the classroom for a health condition? ❒ Yes ❒ No
Please list the medication and what condition it is treating. _____

Has your child had any serious emergencies or operations?
❒ Yes ❒ No Explain_____

Has your child been exposed to violence or other traumatic experiences?
❒ Yes ❒ No Explain _____

During pregnancy, did the mother use:
❒ Alcohol; How often? ❒ Monthly ❒ Weekly ❒ Daily
❒ Drugs; How often? ❒ Monthly ❒ Weekly ❒ Daily
❒ Tobacco; How often? ❒ Monthly ❒ Weekly ❒ Daily
❒ Medications prescribed by physician

Parent's Signature/Legal Guardian: _____ Date: _____