Ogden Weber Community Action Partnership

Early Head Start Pregnant Mom's Program

Dear Expectant Mother,

The Ogden-Weber Community Action Partnership, Inc. (OWCAP) Early Head Start/Head Start is a School Readiness program for all children in need, living in Weber County. The program also provides support services to expectant mothers that qualify for the program.

Early Head Start is for children under the age of 3. OWCAP offers 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. OWCAP offers various Head Start options.

The program is **free** for children and families selected. As an expectant mother, the program will work with you to determine an ongoing source of healthcare and, as appropriate health insurance. The program will provide prenatal and postpartum education and information and will also assist in identifying strengths and needs of the family and provide referrals, as necessary.

Once your baby is born, the program will work with you to develop a plan to transition your baby into the Early Head Start Program, where appropriate.

OWCAP has been providing quality services to children and families in Weber County since 1965.OWCAP Early Head Start/Head Start has caring and highly qualified staff that provide educational, health, and family services for your child and family.

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 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 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 INSURANCE CARD** (**If you have** private insurance- Medicaid, IHC, Chip, etc.)

Other items that are needed if your child is accepted:

- **o FIRST PRENANAL VISIT**
- **o DENTAL EXAM** (to include cleaning and or treatment)

If you need Full Day Child Care with Head Start program services please call the closest center to you for a recruitment appointment.

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 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 Early Head Start/Head Start cost?
Early Head Start/ 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

(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: _____

_____

Family Member Information

Shaded boxes will be completed by agency staff.

Pregnant Mom's Name_____ Birthday_____

CHILDPLUS

Primary Adult (participant) Pregnant Mom

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 unborn child by blood, marriage, adoption, have court-ordered custody, or authorized care giver? Yes No

Last | First | Middle | Preferred

Birthday | Gender | ☐ Lives with Family | ☐ 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**

Expectant Baby Information (If known)

Last | First | Middle | Preferred

Expected Due Date | Gender

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

Ethnicity
☐ Hispanic
☐ Non-Hispanic

English Proficiency: ☐ Primary Language ❑ None ❑ Poor ❑ Moderate ❑ Proficient

Nationality
Country where child was born: _____

Other Language Spoken _____
☐ Poor ☐ Moderate ☐ Proficient

❑ Medicaid Eligibility: Medicaid Number _____

❑ Private Insurance Coverage: Insurance Number_____

❑ Dental Insurance Dental Insurance No._____

Doctor/Dentist

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: _____

Other children in the home

Last	First	Birthday	Gender

Family Information

Shaded boxes will be completed by agency staff.

Pregnant Mom's 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 situation 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	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

	Name		Phone Type	Phone Number	Phone Note	Relationship to Child
Contact 1	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		( )		

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.

Signature _____ Date _____

Verifying Staff Member _____ Date _____

Enrollment Information

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		
Income		
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
F-Foster Child
H-Homeless
P-Public Asst
M-Moderate
O-Over Income

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

Ogden-Weber Community Action Partnership Head Start

Pregnant Mom's Permission / Consent Form

(Please mark each question with a yes or no)

Name:_____ Birth Date: _____

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

I give my permission/consent for Head Start to:

1. Share and receive 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: _____
2. Use photographs or video of myself (promotional purposes, including website, social media, etc.). ❒ Yes ❒ No

I give my permission/consent for:

3. I give permission to any dentist or clinic to release information on me to the Head Start program. ❒ Yes ❒ No
4. I give permission to any doctor or clinic to release information on me to the Head Start program. ❒ Yes ❒ No
5. I am interested in the:
   A. ❒Yes ❒No Serving on the OWCAP Head Start Policy Council
   B. ❒Yes ❒No Serving on the Fatherhood Committee (Father/Father Figures Only)
   C. ❒Yes ❒No Smart Steps Classes (family relationship classes)
7. How did you hear about Head Start?
   ❒Family, friends, word of mouth ❒ Community Agency (name):_____
   ❒Mail or flyer left at my home ❒Fair or event (name/location):_____
   ❒Poster or flyer: Where? _____ ❒Other: _____
8. 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.

_____ _____

Signature Date

Ogden-Weber Community Action Partnership, Inc.
Medical History

Pregnant Mom's Health Status

Name: _____

Do you have any allergies (including foods) that have been verified by a physician? ❒ Yes ❒ No
Do you have an Epi-Pen: ❒ Yes ❒ No

Do you have special dietary needs (cultural, religious, or medical dietary needs)? _____

Please check all that apply.

- ❒ Anemia
- ❒ Seizures
- ❒ Birth defects
- ❒ Bone, joint, and muscle deformity
- ❒ Heart disease (requiring treatment)
- ❒ Epilepsy (current / requiring treatment)
- ❒ Serious Injuries _____
- ❒ Vision problems / glasses
- ❒ Asthma (current / on meds)
- ❒ Frequent Nightmares
- ❒ Diabetes
- ❒ Overweight/Underweight
- ❒ Frequent colds/coughs
- ❒ Hearing Problems/Aids
- ❒ Ear Infections
- ❒ Frequent sore throat/STREP

Please list medication and what condition it is treating: _____

Have you had any serious emergencies, operations, or exposure to or diagnosis of tuberculosis?

❒ Yes ❒ No Explain _____

Have you been exposed to violence or other traumatic experiences?

❒ Yes ❒ No Explain _____

Dental History

- ❒ Dental exam
- ❒ Brushes twice a day regularly
- ❒ Had major dental work done in the last year

Family Medical History

- ❒ Anemia
- ❒ Sickle Cell (Anemia)
- ❒ Easy bruising
- ❒ Easy bleeding
- ❒ Asthma
- ❒ Diabetes
- ❒ Seizures
- ❒ Heart Disease
- ❒ Underweight/overweight
- ❒ Tuberculosis

Do you use:

- ❒ Alcohol
  How often:
  - ❒ Daily
  - ❒ Weekly
  - ❒ Monthly
- ❒ Drugs
  How often:
  - ❒ Daily
  - ❒ Weekly
  - ❒ Monthly
- ❒ Tobacco
  How often:
  - ❒ Daily
  - ❒ Weekly
  - ❒ Monthly
- ❒ Medications prescribed by physician
- ❒ Unknown

Signature: _____ Date: _____