INTER-TRIBAL COUNCIL OF NEVADA
HEAD START PROGRAM
680 GREENBRAE DR., SUITE 265 • SPARKS, NV 89431
P.O. BOX 7440 • RENO, NV 89510
PHONE (775) 355-0600 • FAX (775) 355-0648
FAX (775) 355-5206

Dear Parents,

Thank you for choosing ITCN Head Start for your Early Childhood Education Program.

The following application packet has been developed to make the enrollment process as easy as possible.

Qualifications for enrollment are based on the following criteria:
INCOME- At least 51% of the tribal enrollment of children must be from families who are below the current poverty income guidelines. The ITCN Head Start Program has the capacity to enroll 49% of over income children.
AGE-Children must be three (3) years of age on or before September 30th of the current calendar year.
DISABILITY-No less than 10% of the total enrollment of children must be reserved for children with Disabilities, however, all families that have a child with a Disability must still meet the income guidelines, and include documents that support him/her as such.
TARGET AREA- Target areas are defined as Nevada's Reservations or Colonies, then the surrounding areas.
Children in **FOSTER CARE**, or families that receive **PUBLIC ASSISTANCE** are exempt from income verification, but supporting documentation is required.

The following documents are **REQUIRED**, and will need to be submitted before your child's application can be processed.

- **APPLICATION:** Complete with signature and date.
- **INCOME VERIFICATION**: Check Stub, Income Tax Forms, Scholarship, Grants, Child Support, Social Security, Retirement Benefits, and any Public Assistance.
- **CHILD'S BIRTH CERTIFICATE**: A copy will be taken.
- **CHILD'S CURRENT IMMUNIZATION RECORD:** A copy will be taken.

NOTE: Attached is our Head Start **Physical and Dental Health Forms**.
Scheduling an appointment for your child, and starting these services through the summer months is to your advantage.

You may mail the Application to the Address listed above (Post Office Box) . If your local ITCN Head Start Program is in session, you may leave the application with Head Start Staff.

To be considered for Enrollment Applications MUST be COMPLETED & received by AUGUST 1ST! Applications received after August 1st, may result in your child being placed on the Wait List.

ITCN Head Start APPLICATION

FOR OFFICE USE ONLY

Date Received:	Birth Certificate ☐ Income ☐	Return New	Note
Date Enrolled:	Immunization ☐ S. S. Card ☐	Poverty Guideline	
Center:	Received By: _____		

CHILD INFORMATION

Child's Legal Name FIRST	Middle	Last	DOB	

English Proficiency Primary ☐
Poor Moderate Proficient
Other Language Spoken: _____

Race
American Indian/Alaskan Native ☐ Tribe: _____
Hispanic ☐ Black ☐ White ☐
Native Hawaiian/Pacific Islander ☐ Asian ☐

GENERAL INFORMATION

Mailing Address:	City	State	Zip
Physical Address:	City	State	Zip

Disability Information Children with Disabilities may receive priority for Head Start Enrollment, if the family is income eligible.

Does your child have a Disability?	Yes	No	Attach documentation (IEP, Diagnosis)
Has the Disability been professionally diagnosed?	Yes	No	
Is your child receiving special services for the Disability?	Yes	No	
Does your child require special accommodations?	Yes	No	
In your opinion, does your child have a Disability that has not yet been diagnosed?	Yes	No	

If yes, explain: _____

PRIMARY ADULT PARENT/GUARDIAN

First	MI	Last	
Home Phone:	Cell Phone:	Work Phone:	Relationship to Child:

English Proficiency Primary ☐ Poor Moderate Proficient
Other Language Spoken: _____
Email:

Race American Indian/Alaskan Native; Tribe: _____
White ☐ Hispanic ☐ Black ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐

Family Type Two Parent Family ☐ Single Parent (Mother Figure Only) ☐ Single Parent (Father Figure Only) ☐
Single Parent (living with partner) ☐ Foster Family ☐ Other Relatives ☐ Explain: _____

Employment Status Full Time ☐ Part Time ☐ Unemployed ☐ Homemaker ☐
Seasonal(Agricultural) ☐ Seasonal (non Agricultural) ☐ Retired or Disabled ☐

Education Highest level of Education completed? _____ Currently Enrolled in School or Training Program? _____

Types of Services Received:

Child Support/Alimony ☐	WIC ☐	
Supplemental Security Income (SSI) ☐	Foster Care Subsidy ☐	Food Stamps (SNAP) ☐
Public Assistance/Welfare; TANF ☐	Public Housing Assistance ☐	Energy Assistance Program ☐
Medicaid/Medicare, NV Check Up ☐	Unemployment ☐	No Services Received ☐

SECONDARY ADULT PARENT/GUARDIAN

First	MI	Last	
Home Phone:	Cell Phone:	Work Phone:	Relationship to Child:

English Proficiency Primary ☐ Poor Moderate Proficient
Other Language Spoken: _____
Email:

Race American Indian/Alaskan Native; Tribe: _____
White ☐ Hispanic ☐ Black ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐

Employment Status	Full Time ☐	Part Time ☐	Unemployed ☐	Homemaker ☐
	Seasonal(Agricultural) ☐	Seasonal (non Agricultural) ☐	Retired or Disabled ☐	

Education: Highest level of Education completed? _____ Currently Enrolled in School or Training Program? _____

Types of Services Received:					
Supplemental Security Income (SSI)	☐	Child Support/Alimony	☐	WIC	☐
Public Assistance/Welfare; TANF	☐	Foster Care Subsidy	☐	Food Stamps (SNAP)	☐
Medicaid/Medicare, NV Check Up	☐	Public Housing Assistance	☐	Energy Assistance Program	☐
		Unemployment	☐	No Services Received	☐

Military: Is Parent/Guardian **CURRENTLY** a member of the U.S. Military? Specify: _____

Additional Family Members	DOB	Relationship to Child

Income	Provide Supporting Documents (Check Stubs, W-2's, letters, etc).				
Family Member			Source		
	Employment	Unemployment	Disability	TANF	Other
	Employment	Unemployment	Disability	TANF	Other
	Employment	Unemployment	Disability	TANF	Other

Additional Notes/Information:

I certify that the information provided in support of this application is accurate and true to the best of my knowledge.

Signature of Parent/Guardian: _____ **Date** _____

Application must be signed by Parent or Guardian in order to be considered for enrollment.

INCOME VERIFICATION - FOR OFFICE USE ONLY

The application of _____ has been reviewed for participation in Head Start services. The family qualifies by meeting certain eligibility requirements and/or priority criteria established by the Inter Tribal Council of Nevada Head Start Program. The following documentation has been examined to verify income eligibility.

☐ W-2 Statement(s)	☐ 1040 Tax Statement	☐ Employment/Self Employment
☐ Social Security	☐ Child Support/Alimony	☐ Unemployment Compensation
☐ Per Capita Payment	☐ Scholarships/Grants	☐ Indian General Assistance
☐ Pension/Retirement	☐ TANF/SSI Cash Aid	☐ Foster Care/Adoption Subsidy

☐ Regular support from an absent family member, or someone not living in the home.

TOTAL GROSS ANNUAL AMOUNT $ _____ **EARNED FROM** _____ , _____ **TO** _____

FAMILY SIZE _____ **POVERTY GUIDELINE** **ABOVE** **BELOW**

REVIEWED BY: _____ - _____ - _____

NEVADA HEALTHY KIDS (EPSDT)/WELL BABY/WELL CHILD

Initial New Patient Screening Form (CPT 99381-99385)

Name_____ **Date** _____ **DOB** _____ **Age** _____ **Sex**_____

Medicaid# _____ **Parent/Guardian Name** _____ **Provider NPI**_____

Patient's Medical History

Birth Weight_____ **Birth Length** _____ **Serious Injury/Illness**_____ **Surgeries**_____

Menarch/Sexual History (if applicable) _____ **Behavioral/Emotional History**_____

Family Medical History (Check disease & indicate family member with the problem: P-parent G-grandparent B-Brother, S-Sister)

Asthma/Allergies _____	**Heart Attack/Stroke**_____	**Scoliosis/Arthritis**_____	**Retardation**_____
Birth Defects_____	**High Blood Pressure**_____	**Substance Abuse**_____	**Mental Illness**_____
Blood/Sickle Cell_____	**Kidney/Liver Disease**_____	**Urinary Problems**_____	**Disabilities**
Cancer_____	**Lung Disease**_____	**Ulcers/Stomach Upset**_____	**Other**_____
Diabetes_____	**Obesity**_____	**Bowel Problems**_____	_____

Growth/Vital Signs

Ht_____ (_____ %) **Temp**_____ **Pulse**_____ **Resp**_____ **B/P**_____ **Allergies**_____

Wt_____ (_____ %) **Current Medications**_____ **Nutrition**_____

HC or BMI_____ (_____ %) **Present Concerns**_____

Physical Exam-unclothed (N- Normal A- Abnormal NE- No exam)

N	A	NE		N	A	NE		N	A	NE	
____	____	____	**Appearance**	____	____	____	**Nose**	____	____	____	**Abdomen**
____	____	____	**Head/Face**	____	____	____	**Mouth/Teeth**	____	____	____	**Genitalia**
____	____	____	**Hair/Scalp**	____	____	____	**Neck**	____	____	____	**Musculoskeletal**
____	____	____	**Eyes/Vision Screen**	____	____	____	**Heart/Lungs**	____	____	____	**Extremities**
____	____	____	**Ears/Hearing Screen**	____	____	____	**Skin/Nodes**	____	____	____	**Neuro**

Describe any abnormalities_____

Developmental/Emotional Behavior

Age/Culturally appropriate (i.e. through parental interview, observation or screening tool): _____ **Yes** _____ **No**

Name of screening tool, if used: _____ **Referral:** _____

Anticipatory Guidance/Nutrition/Safety (Check each one that is discussed with patient/caregiver.)

_____ **Nutrition**	_____ **Adequate Sleep**	_____**Limit TV/Computer Time**	_____**Maternal/Caregiver Depression**
_____ **Vitamins**	_____ **Active Play**	_____ **Social/School Adjustment**	
_____ **Brush Teeth/Visit Dentist**	_____ **No Smoking in House/Car**	_____ **Privacy/Hygiene**	
_____ **Family Relationships**	_____ **Car Seat/Safety Belt**	_____ **Puberty/Sex**	

Impression

Well Child ____**Yes** ____**No Dx:** _____ **Normal Growth/Development** ____**Yes** ____**No Dx:** _____ **Next screening due**_____

Treatment/Plan/Referral

_____ **Fluoride Varnish Application** _____ **Refer to dentist** _____**Refer to Specialist** **Type of Specialist**_____

Immunizations Given _____ Up-to-date

_____ **DTaP** (DTaP, DTaP-Hib, DTaP-HepB-IPV, DT, Tdap, Td)	_____ **MMR**(MMR, MMRV)
_____ **Hib** (Hib, Hib-HepB, DTaP-Hib)	_____ **Meningococcal** (MCV4, MPSV4)
_____ **Hep A**	_____ **Pneumococcal** (PCV, conjugate, PPV, polysaccharide)
_____ **Hep B** (HepB, Hib-HepB, DTap-HepB-IPV)	_____ **Polio** (IPV, DTaP-HepB-IPV)
_____ **HPV**	_____ **Rotavirus**
_____ **Influenza** (TIV, LAIV)	_____ **Varicella** (Var, MMRV)

Laboratory Ordered _____Up-to-date

_____ **Hemoglobin/Hematocrit**	_____ **Lead Testing**	_____ **PKU**	
_____ **Sickle Cell**	_____ **TB Test**	_____ **U/A**	_____ **Other**_____

Provider Signature: _____ **Date:** _____

CHILD HEALTH RECORD:

FORM 5, DENTAL HEALTH

CHILD'S NAME:_____ **SEX:**_____ **BIRTHDATE:**_____

HEAD START CENTER:_____ **PHONE:**_____

ADDRESS:_____

PART I. TO BE COMPLETED BY HEAD START STAFF (COMPLETE AT INTERVIEW)

1. IS THE CHILD NOW RECEIVING: *If "yes," include length of time receiving fluoride*
   - Topical Fluoride Application? No_____ Unknown_____ Yes_____
   - Fluoridated water? No_____ Unknown_____ Yes_____
   - Fluoride Supplement diet? (tablets_____, liquid_____) No_____ Unknown_____ Yes_____

2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAN THE PARENT KNOWS ABOUT?

3. CHILD (___HAS, ___HAS NOT) PREVIOUSLY SEEN A DENTIST.
   Dentist's name_____ Date last visit_____

4. CHILD (___IS, ___IS NOT) UNDER A PHYSICIAN'S CARE.
   Physician's name_____

5. CHILD (___IS, ___IS NOT) RECEIVING MEDICATION.
   Type_____

6. CHILD IS REPORTED TO HAVE *(Give details or attach Health History, Form 2A).*

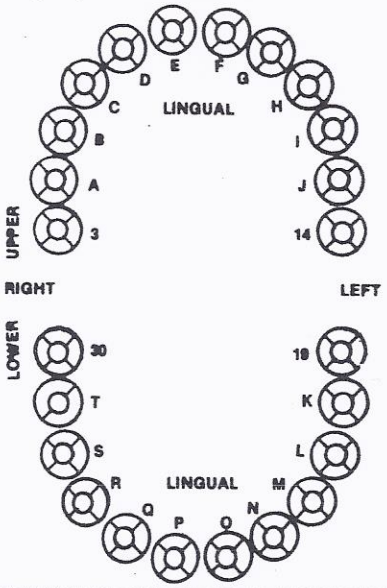
	YES	NO		YES	NO
Allergies	___	___	Liver Dis.	___	___
Asthma	___	___	Rheumatic Fever	___	___
Bleeding	___	___	Sickle Cell Dis.	___	___
Diabetes	___	___	Other (List Below)	___	___
Epilepsy	___	___	_____		
Heart/Vascular Dis.	___	___	_____		

7. SOURCE OF REIMBURSEMENT OR SERVICES
   - ☐ EPSDT/Medicaid
   - ☐ Federal, State, or local Agency _____
   - ☐ Head Start
   - ☐ In-kind Provider_____
   - ☐ Parents/Guardians
   - ☐ Other (3rd Party)_____

8. PRIORITY GROUP
   - ☐ A. Needs Attention Immediately
   - ☐ B. Needs Attention Soon
   - ☐ C. Needs Routine Care

PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER

9. ORAL CONDITIONS BEFORE TREATMENT: *missing (⊗), decayed (▨), or filled (■); indicate restorations you perform in Item 10.*



10. EXAMINATION AND TREATMENT RECORD *(List recommended services in order).*

Tooth # or Letter	Surfaces	Description of Work	Treatment Approved	Date Service Performed MO.	DAY	YR.	A.D.A. Procedure Number	Actual Charges (Fee)	

11. DENTAL NEEDS *(Check one or more and return 3 copies to Head Start after first visit).*
   - ☐ A. TREATMENT (restoration, pulp therapy, extraction)
   - ☐ B. CLEANING
   - ☐ C. FLUORIDE
   - ☐ D. OTHER
   - ☐ E. NO PROBLEMS

   Approximate number of visits_____. Approximate cost_____.

12. CHILD ORAL HEALTH SUMMARY *(Complete and return 2 copies to Head Start after final visit).*
   All planned treatment (___is, ___is not) complete. If not, explain here, as well as items checked.
   _____
   _____

   - ☐ a. Routine recall visits
   - ☐ b. Special home emphasis, oral hygiene
   - ☐ c. Dietary problem(s)
   - ☐ d. Developmental problem(s)
   - ☐ e. Harmful oral habits
   - ☐ f. Needs fluoride supplement

   I certify that I have completed the service(s) listed in Part II, Item 10, and that itemized charges do not exceed my usual and customary fees.

   Signature_____ Date_____

INTERVIEWER: GO TO FORM 6