## Applicant & Family Member Information

### Applicant (Pregnant Mom)

| First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| Race | Hispanic | English Proficiency | Other Language | Other Language Proficiency |
|---|---|---|---|---|
| ☐ Asian ☐ American Indian/Alaska Native<br>☐ Black<br>☐ White ☐Hawaiian/Pacific Islander<br>☐ Other:_____<br>CDIB ☐ Yes ☐ No<br>If yes, list tribe: | ☐ Yes<br>☐ No | ☐ None<br>☐ Little<br>☐ Moderate<br>☐ Proficient | | ☐ Poor<br>☐ Moderate<br>☐ Proficient |

| Primary Health Coverage | Other Health Coverage | Medicaid | Doctor | Dentist |
|---|---|---|---|---|
| | | ☐ Not Eligible<br>☐ On Medicaid<br>☐ Potentially Eligible | | |

☐ *No Health Insurance Coverage*

### Applicant Continued (Pregnant Mom)

| Highest Grade Completed | | Employment Status | | Child's Relationship | Legal Custody | Check all that apply: |
|---|---|---|---|---|---|---|
| ☐ Associate's<br>☐ Bachelor's<br>☐ Col Deg/Train<br>☐ Col or Adv Train<br>☐ GED | ☐ Grade 10<br>☐ Grade 11<br>☐ Grade 12<br>☐ < Grade 9<br>☐ HS Graduate<br>☐ Master's | ☐ Full Time<br>☐ Part Time<br>☐ Seasonal<br>☐Unemployed | ☐ Full Time & Training<br>☐ Part Time & Training<br>☐ Training or School<br>☐ Retired or Disabled | ☐Natural/Adopted/ Step<br>☐ Grandchild<br>☐ Niece/Nephew<br>☐ Foster<br>☐ Other | ☐ Yes<br>☐ No | ☐ Lives with Family<br>☐ Provides Financial Support<br>☐ Teen Parent |

**Are there any legal restrictions that we need to be aware of?**
**☐ Yes ☐ No**

**If yes, you must provide us with a copy of the documentation.**

### Adult 2

| First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| Race | Hispanic | English Proficiency | Other Language | Other Language Proficiency |
|---|---|---|---|---|
| ☐ Asian ☐ American Indian/Alaska Native<br>☐ Black<br>☐ White ☐ Hawaiian/Pacific Islander<br>☐ Other: ☐ Multi-Racial | ☐ Yes<br>☐ No | ☐ None<br>☐ Little<br>☐ Moderate<br>☐ Proficient | | ☐ Poor<br>☐ Moderate<br>☐ Proficient |

| Highest Grade Completed | | Employment Status | | Child's Relationship | Legal Custody | Check all that apply: |
|---|---|---|---|---|---|---|
| ☐ Associate's<br>☐ Bachelor's<br>☐ Col Deg/Train<br>☐ Col or Adv Train<br>☐ GED | ☐ Grade 10<br>☐ Grade 11<br>☐ Grade 12<br>☐ < Grade 9<br>☐ HS Graduate<br>☐ Master's | ☐ Full Time<br>☐ Part Time<br>☐ Seasonal<br>☐Unemployed | ☐ Full Time & Training<br>☐ Part Time & Training<br>☐ Training or School<br>☐ Retired or Disabled | ☐Natural/Adopted/ Step<br>☐ Grandchild<br>☐ Niece/Nephew<br>☐ Foster<br>☐ Other | ☐ Yes<br>☐ No | ☐ Lives with Family<br>☐ Provides Financial Support<br>☐ Teen Parent |

**Family Information, Income & Contacts**

Pregnant mom's Name: _____

## Family Information

| Living Address | Address Line 2 | Zip | City | State | County |
|---|---|---|---|---|---|
| | | | | | |
| **Mailing Address (if different)** | **Address Line 2** | **Zip** | **City** | **State** | **County** |
| | | | | | |

| Name & Phone Numbers | Type (*check one*) | |
|---|---|---|
| | ☐ Cell ☐ Home ☐ Work | ☐ Phone # _____ |
| | ☐ Cell ☐ Home ☐ Work | ☐ Phone # _____ |
| | ☐ Cell ☐ Home ☐ Work | ☐ Phone # _____ |

| Parental Status (check one) | Primary Language at Home | Homeless Family | Active Duty Military | Referred by Child Welfare Agency | Receiving Food Support | WIC |
|---|---|---|---|---|---|---|
| ☐ One ☐ Two | | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

## Emergency Contacts

**Contact 1**

| Name | Relationship | Emergency Contact | Release To |
|---|---|---|---|
| | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **Address** | **Zip** | **City** | **State** |
| | | | |
| **Phone # 1** | **Phone # 2** | **Phone # 3** | |
| ☐ Cell ☐ Home ☐ Work | ☐ Cell ☐ Home ☐ Work | ☐ Cell ☐ Home ☐ Work | |

**Contact 2**

| Name | Relationship | Emergency Contact | Release To |
|---|---|---|---|
| | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **Address** | **Zip** | **City** | **State** |
| | | | |
| **Phone # 1** | **Phone # 2** | **Phone # 3** | |
| ☐ Cell ☐ Home ☐ Work | ☐ Cell ☐ Home ☐ Work | ☐ Cell ☐ Home ☐ Work | |

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 _____

# Leech Lake Early Head Start
# Expectant Families Program
## *Family/Pregnancy History*

Expectant Family _____ Date _____

How did you find out about our program? _____

### *Prenatal Information*

What week of pregnancy? _____ What is your expected due date? _____
Date you first received prenatal care _____

Do you have a prenatal provider? ☐ Yes ☐No
If yes what type? ☐ Private ☐IHS ☐Other, _____
Name of Provider _____
Date of last visit _____
What hospital will you use for delivery?_____

Have you seen a dentist during your pregnancy? ☐ Yes ☐No
Date of last exam _____ Provider_____

### *Family*

___ Diagnosed Disability, if yes list _____
___ Suspected Disability, if yes list _____
___ Teen Pregnancy
___ Medical Concerns
___ Nutritional Concerns
___ English as Second Language
___ Single Parent (in school or working)
___ Blended Family
___ Unemployed
___ Limited Resources
___ Recent Divorce or Separation
___ Deceased Parent
___ Domestic Violence
___ Substance Abuse
___ Homelessness
___ Major Change in Family
___ Home Safety Hazards
___ Other, explain_____

***Current or Previous Pregnancies (please check all that apply)***

| Complications | Current | Previous |
|---|---|---|
| Pain | | |
| Bleeding | | |
| C-Section | | |
| Fatigue | | |
| Pre-Term Labor | | |
| Diabetes | | |
| Pregnancy Induced Diabetes | | |
| Anemia | | |
| Headaches | | |
| Swelling | | |
| Sickle Cell | | |
| Hypertension | | |
| Pregnancy Induced Hypertension | | |
| Neonatal Death | | |
| Miscarriage | | |
| Bed Rest / Hospitalization | | |
| Due to: | How long? | |

Other:

Signature of Specialist _____ Date _____

Signature of Applicant _____ Date _____

# Leech Lake HeadStart/EarlyHS Household Size and Income Information

**Parent/Guardian: Full Name:** _____

**ENROLLED CHILD'S NAME:** _____
**Number of Adults in Family:** _____ **Number of Children in Family:** _____

**Number of Adults contributing to the Income:** _____ **Annual Income:** _____
***(Must provide documentation for each contributing member)***
**Please List All Family Members:**

_____ **DOB** _____
_____ **DOB** _____
_____ **DOB** _____
_____ **DOB** _____
_____ **DOB** _____

**(USE BLANK SHEET OF PAPER FOR ADDITIONAL NAMES & BIRTHDATES)**

## >> MUST PROVIDE DOCUMENTATION FOR ALL INCOME SOURCES<<

| *INCOME SOURCE* | *AMOUNT* | *FREQUENCY* |
|---|---|---|
| **Non-Agricultural Earned Income (ie. wages, tips)** | | ☐ Weekly<br>☐ Every 2 weeks<br>☐ Twice a month<br>☐ Monthly<br>☐ Annually |
| **Public Assistance. Welfare (ie. TANF, MFIP)** | | ☐ Weekly<br>☐ Every 2 weeks<br>☐ Twice a month<br>☐ Monthly<br>☐ Annually |
| **Social Security/Pension** | | ☐ Weekly<br>☐ Every 2 weeks<br>☐ Twice a month<br>☐ Monthly<br>☐ Annually |
| **Supplemental Security Insurance (SSI)** | | ☐ Weekly<br>☐ Every 2 weeks<br>☐ Twice a month<br>☐ Monthly<br>☐ Annually |
| **Foster Care/Adoption Subsidy** | | ☐ Weekly<br>☐ Every 2 weeks<br>☐ Twice a month<br>☐ Monthly<br>☐ Annually |
| **Unemployment Insurance** | | ☐ Weekly<br>☐ Every 2 weeks<br>☐ Twice a month<br>☐ Monthly<br>☐ Annually |
| **Child Support/Alimony** | | ☐ Weekly<br>☐ Every 2 weeks<br>☐ Twice a month<br>☐ Monthly<br>☐ Annually |

## >>>>>IMPORTANT<<<<<

**DON'T FORGET TO SIGN THE BACK OF THIS PAGE.**
**PLEASE CONTINUE ON BACK SIDE OF THIS FORM.**

**Income Verification:**

☐ 1040 Tax Statement ☐ W2 Statement ☐ Pay Stubs ☐ Income Declaration

☐ Public Assistance Printout ☐ Unemployment ☐ Other: Specify _____

**Special CACFP Verification:** ***Annual Amount***

☐ Food Stamps _____

☐ MFIP _____

☐ Foster Child ☐ SSI

# NO CHILD WILL BE ENROLLED UNTIL INCOME VERIFICATION IS PROVIDED.

. ***( Head Start Performance Standards: 1305.4 c, d, e)***

**Parent/Guardian Signature** _____ Date _____

Head Start Staff Signature _____ Date _____

**OFFICE USE ONLY:**

# in Household_____

IE / OI

Amount _____

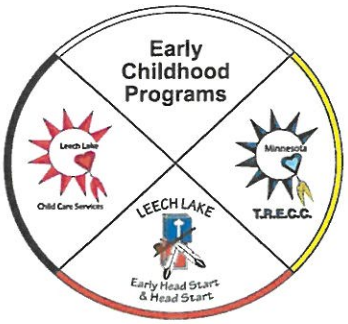
Income Verification amount _____

*Income source:*

- □ Wages
- □ MFIB (county printouts)
- □ SS / SSI
- □ Foster Care
- □ Unemployment
- □ Notarized No Income
- □ Other:_____

Verified by:_____

Date




# Leech Lake Head Start / Early Head Start

## AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

**To:**_____

**(County Agency, School, Other)**

You are hereby authorized to release / exchange the following requested information to the: **Leech Lake Early Childhood Development**

**190 Sailstar Drive NW**

**Cass Lake, Mn. 56633**

**Phone (218) 335-8345 Fax # (218) 335-8255**

_____ _____

**(Name of Parent / Child)** **(Date Of Birth)**

**Please send:** _____

I understand that my records are protected under appropriate Privacy Laws, and cannot be disclosed to any other party without my written consent. I also understand that this consent expires automatically one (1) year from the date below.

_____ _____

Parent / Guardian Signature Date

# Leech Lake Early Head Start
# Expectant Families Program
# Health/Nutrition Assessment

Expectant Mother_____ Date_____

## Health: Part 1

Pre-pregnant weight: _____ Pregnancy Weight: _____ Height: _____

Have you lost weight with out trying? No ❒ Yes ❒

Are you taking prenatal vitamins and iron? No ❒ Yes ❒

Do you or have you experienced heartburn or indigestion? No ❒ Yes ❒

Are you currently taking over the counter medications? No ❒ Yes ❒

If yes, list _____

Do you smoke or use smokeless tobacco? No ❒ Yes ❒

Are you or have you experienced constipation? No ❒ Yes ❒

Are you currently drinking alcohol? No ❒ Yes ❒

## Nutrition: Part 2

Are you on a special diet? No ❒ Yes ❒▶ Please give details:_____

Are there any foods you do not eat for medical, religious, or personal reasons?

No ❒ Yes ❒▶ Please give details: _____

_____

How would you describe your appetite? Good ❒ Fair ❒ Poor ❒

**Cravings for any of the following:**

| | | |
|---|---|---|
| Cornstarch ❒ | Dirt ❒ | Coffee grounds ❒ |
| Clay ❒ | Plaster ❒ | Starch ❒ |
| Toothpaste ❒ | Ice ❒ | Laundry Soap ❒ |

**Had any of the following?**

| | |
|---|---|
| Nausea | ❒ |
| Vomiting | ❒ |
| Constipation | ❒ |
| Diarrhea | ❒ |

**Meals usually eaten:**

| | |
|---|---|
| Breakfast | ❒ |
| Snack | ❒ |
| Lunch | ❒ |
| Dinner | ❒ |

Other: _____

**There is a back side to this form**

1. How much water do you drink daily? _____

2. What kind of water do you drink?
   ❒ Distilled ❒ Spring ❒ Tap ❒ Flavored

3. Do you have a working stove, oven and refrigerator where you live? No ❒ Yes ❒

4. Were there any days last month when you did not have enough food to eat or enough money to buy food? No ❒ Yes ❒

5. Do you plan on breast feeding? No ❒ Yes ❒
   List any concerns regarding breast feeding _____
   _____

What concerns or questions do you have about health or nutrition?

_____

_____

_____

Signature of Applicant_____ Date _____

Specialist Signature_____ Date _____