

CENTRAL TRIBES OF THE SHAWNEE AREA, INC.
1535 N. MCKINLEY SHAWNEE, OKLAHOMA 74801
PH.(405)275-4870 FAX(405)275-9684

ENROLLMENT APPLICATION

START HERE→ PLEASE READ THIS INFORMATION FIRST, BEFORE COMPLETING YOUR CHILD'S APPLICATION. BE SURE TO PROVIDE THE REQUIRED DOCUMENTATION AT THE TIME OF APPLICATION OR WE CANNOT PROCESS YOUR CHILD'S APPLICATION.

Head Start Performance Standards, 1302.11(a) Families must live in CTSA service area of Pottawatomie, Payne, Lincoln, or Cleveland Counties to be eligible! CTSA is a federally funded Early Head Start/Head Start program. We have three locations: Cushing, Shawnee, and Stroud.. Cushing and Stroud are Head Start ONLY (three to five) – In Shawnee, we have both Early Head Start (birth to three) and Head Start (three to five). ****Children with disabilities are encouraged to apply** Native American based program – All welcome!**

EARLY HEAD START (EHS) - CTSA EHS provides free, quality curriculum based developmentally appropriate services for low income infants, toddlers, and their families.

HEAD START (HS) – CTSA HS provides free pre-school education and comprehensive services to low income children and their families (three to five). All classrooms implement quality curriculum based developmentally appropriate services while remembering you are your child's first teacher, uniquely combining the two to enrich lives.

REQUIRED DOCUMENTATION – A Completed Application! Be sure to select what location (Cushing, Stroud, Shawnee) and Program Option (EHS? HS?) All questions that apply to your child, and your family must be answered! Incomplete information will only delay the application process! We MUST have proof of:

- State Certified Birth Certificate/Passport for ALL CHILDREN'S APPLICATIONS.
- Current Immunization Record for ALL APPLICATIONS.
- Verification of Income*Need at least 2 check stubs/Income Statement/TANF (SNAP) letter/SSI verification/Foster Care placement verification for ALL APPLICATIONS. If BOTH BIOLOGICAL parents are in the home, we must have income information for BOTH. If only One Biological parent has custody – we only need income for the custodial parent! If biological parent with custody is re-married, we also need spouse's income!
- Proof of Residence: utility bill, or rental/lease contract from landlord

→IF YOUR FAMILY QUALIFIES FOR THE FOLLOWING, WE WILL NEED TO VERIFY QUALIFYING DOCUMENTATION:

- >WIC > MediCaid/SoonerCare (letter/card) > Source of HealthCare (Tribal/IHS, Private Insurance, etc)
- > Tribal Membership/CDIB card or letter on Tribal Letterhead (Child/Parent)
- > If your child has a Documented Disability, we will need a copy of his/her IFSP or IEP.

→ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL.

→THIS APPLICATION DOES NOT GUARANTEE ACCEPTANCE/ENROLLMENT IN THE CTSA PROGRAMS.

→ALL INFORMATION GATHERED WILL BE USED TO HELP CTSA TO DETERMINE WHETHER OR NOT YOUR CHILD IS ELIGIBLE FOR THE PROGRAM OPTION SELECTED ON APPLICATION.

→CTSA WILL PRIORITIZE EACH APPLICATION BASED ON THIS INFORMATION TO DETERMINE THE GREATEST NEED, PER THE HEAD START PERFORMANCE STANDARDS, 1302.12.

****Please tell us how you heard about our program:** _____

THANK YOU! ☺

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Is child in FOSTER CARE? PROTECTIVE CUSTODY?

Today's Date: _____

→**SELECT LOCATION:** CUSHING STROUD SHAWNEE ROLLOVER

→**SELECT PROGRAM OPTION:** *Head Start* *Early Head Start*

APPLICANT INFORMATION: *Is applicant? Male Female Homeless? Foster Child?

Name: _____ Date of Birth: _____
(first) (middle) (last) (provide verification)

Race/Ethnicity: _____ Tribal Affiliation: _____ CDIB: Yes No

Primary Language: English Spanish Other _____ 2nd Language? _____

Has this child been previously enrolled in another EHS/HS program? Yes No

If Yes, Program Name: _____ Where: _____

Has this child been identified as having a disability requiring Early Intervention Special Education and/or related services? Yes No If Yes, does this child have a current IFSP or IEP? Yes No ***Please Provide a Copy***

Please briefly state the nature of the disability: _____

APPLICANT INSURANCE INFORMATION: Does the applicant (Child/Self) have medical coverage? Yes No

Medicaid SoonerCare Indian Health Services (IHS) - Clinic: _____ Third Party (Private Ins.)

Policy Number: _____ Group Number: _____

Does the applicant have Dental Coverage: Yes No Dental Services through IHS clinic: Yes No

Dental Carrier: _____ Policy Number: _____

BIOLOGICAL/CUSTODIAL PARENT LEGAL GUARDIAN FOSTER – INFORMATION

Parent/Legal Guardian First Name	M.I.	Last Name	Birth date
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Marital Status: Married Single Divorced Separated Widowed BOTH Biological Parents in Home.

Physical Home Address	City	State	Zip
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Mailing Address – IF DIFFERENT	City	State	Zip
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COUNTY	Contact Phone #1	Contact Phone #2	Contact Phone #2
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HOUSEHOLD / FAMILY MEMBER INFORMATION → List <u>ALL HOUSEHOLD MEMBERS</u> - use back of sheet if necessary			
NAME (FIRST, MI, LAST)	SEX	RELATIONSHIP TO APPLICANT	BIRTH DATE
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____
4) _____	_____	_____	_____
5) _____	_____	_____	_____
6) _____	_____	_____	_____
7) _____	_____	_____	_____

→As Parent/Legal Guardian, I understand the *Head Start Performance Standards, 1304.20(a)(ii)*, require each child to be current in age appropriate immunizations as required by the Oklahoma Department of Health and will participate in daily tooth brushing using fluoride toothpaste.

→As Parent/Legal Guardian, I understand the *Head Start Performance Standards, 1304.20(b)*, require each child to receive the following screenings of which I, the Parent/Guardian, am responsible for the Physical and Dental Exams only:

- Physical Exam (which includes a Hct/Hgb, Lead screen, and blood pressure check) → Dental Exam
 → Vision Screening → Hearing Screening → Development Assessment → Speech Assessment

CTSA provides the Vision, Hearing, Developmental, and Speech Screenings/Assessments

Documentation for State approved Exceptions to any of the above for medical or religious reasons will be required.
 In addition to the above, I acknowledge that: Initial

1. My child may be transported for Head Start services (HEAD START ONLY). Yes No _____
2. My child may be observed in a group setting by a Mental Health Professional. Yes No _____
3. My child may be photographed for use in EHS/HS Public Relations program. Yes No _____
4. CTSA may access my child's immunization record through the Oklahoma State Immunization Information System (OSIIS). Yes No _____

By signing my name, I understand regular attendance (85% or more) is required, *Head Start Performance Standard, 1302.16*.

- I understand I am encouraged to volunteer in the EHS/HS center, *Head Start Performance Standard, 1302.50*.
- I agree to comply with the regulations of the program. I understand that all information provided will remain confidential.
- I understand this application is valid only for the school year in which it is signed by Parent/Legal Guardian.
- I certify that I and my applying child live within the jurisdiction of CTSA, either Pottawatomie, Payne, Cleveland, or Lincoln counties; that I will be required to show proof of address (utility bill, rental/lease agreement).
- I understand that 3rd party verification of my submitted documentation may be conducted.
- I understand that falsifying any information to appear more eligible is FRAUD and will disqualify my family immediately.

 Applicant/Parent/Legal Guardian Signature

 Date

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THIS PAGE TO BE COMPLETED BY AUTHORIZED STAFF ONLY

OFFICE USE ONLY

- | | |
|--|---|
| <input type="checkbox"/> TANF/SNAP BENEFITS | <input type="checkbox"/> INCOME VERIFICATION |
| <input type="checkbox"/> SSI DOCUMENTATION | <input type="checkbox"/> BIRTH CERTIFICATE |
| <input type="checkbox"/> FOSTER CARE DOCUMENTATION | <input type="checkbox"/> IMMUNIZATION RECORD |
| <input type="checkbox"/> WIC | <input type="checkbox"/> CDIB/TRIBAL ENROLLMENT |
| <input type="checkbox"/> Face to Face interview | <input type="checkbox"/> Phone interview |

AUTHORIZED STAFF SIGNATURE & TITLE

DATE

- | | |
|--|--|
| <input type="checkbox"/> INCOME ELIGIBLE | <input type="checkbox"/> INCOME ELIGIBLE 100-130% |
| <input type="checkbox"/> OVER INCOME 49% AI/AN | <input type="checkbox"/> OVER INCOME 10% Non-AI/AN |

1ST YEAR OF SERVICE _____ 2ND YEAR OF SERVICE _____ 3RD YEAR OF SERVICE _____

CAP60 ENTRY—ERSEA STAFF ONLY

ROLLOVER *Address Verification? _____