Standing Rock 0-5 Head Start Program

Post Office Box 768
200 Proposal Avenue
Fort Yates, ND 58538
(701) 854-7250
Fax (701) 854-7257

2020-2021 School Year
Prenatal Application

What is Head Start/Early Head Start?

Head Start and Early Head Start are comprehensive child development programs which serve children from prenatal to age 5, pregnant women, and their families. They are child-focused programs, and have the overall goal of increasing the social competence of young children in either low-income and homeless families or both.

What is Standing Rock 0-5 Head Start Program?

Our goal is to provide a full range of services to meet the needs of mothers from prenatal to postpartum care and their families. The comprehensive care provided from cognitive, emotional, physical, nutritional, mental health and Lakota language and cultural development of the expectant families.

How to apply for Head Start/Early Head Start?

Please read this eligibility application carefully and fill it out completely.

What happens Next?

When we receive your enrollment application, it will be reviewed and you will be contacted if we need more information. You will receive additional documents to fill out to complete the registration process when our family service worker contacts you to set up an appointment.

CHECKLIST:

These documents are required within 30 days of enrollment.

- Completed Enrollment Application (required for determining eligibility)
- Family's Proof of Income (required for determining eligibility)
- Dental Examination
- Physical Examination
- Copy of Medical Insurance
- Adult Health History
- Parental Permission to Participate (in program screenings)

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2020-2021 School Year
Prenatal Enrollment Information

Center Applying for: _____Home Base

Date Intake/Application Completed: _____/_____/_____ (Office Use Only)

ELIGIBLE PRENATAL DEMOGRAPHICS:

First: _____ Middle: _____ Legal Last Name: _____

DOB: _____/_____/_____ Race: _____

Ethnicity: _____ Gender (Circle): Male/Female

Language (Check): __English __Lakota __Spanish __Other

Marital Status (Check): __Single __Married __Separated __Divorced

Role in the Household (Check): __Mother/Mother Figure __Father/Father Figure __Homeless

__No Longer a Family Member __Family Member Residing at Different Address

****

Living Address: _____ Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

_____

Occupation (Check): __Employed Full-time/In-school part-time __School full-time __Unemployed

__In-School Full-time/Employed Part-time __Part-time __Seasonal __Employed __Other

__N/A __In Job Training Program Occupation Start Date: ____/____/____

****

Education (Check Highest Level of Education Completed):

Elementary (Check one) - __4th Grade __5th Grade __6th Grade __7th Grade __8th Grade

High School (Check one)- __9th Grade __10th Grade __11th Grade __12th Grade – No Diploma

__High School Diploma or Equivalent

Degree (Check one)- __AA __BS __MA __PHD __Some College – No Diploma

__Other __ CDA Education Start Date: _____/_____/_____

ADULT INFORMATION:

Concerns about your overall health and development: __Yes __No Describe Concerns:

_____

Applicant currently pregnant? __Yes __No Due Date: ____/____/____

Person is a teen mother? __Yes __No Teen mother dropped out of school? __Yes __No

Reason: _____

Are you willing to pursue educational opportunities? __Yes __No If yes, what assistance would you need in order to pursue these goals?

(Specify)_____

_____

FAMILY INFORMATION:

Are you Head of Household? __Yes __No Family Type? __Foster Parent __Grandparents __Other Relatives __Single Parent/Father Figure __Single Parent/Mother Figure __Two Parent

****

Family Housing Type (Check):

__Apartment __House __BIA School Housing __Mobile Home/Trailer __SRHA Housing __Living with Parents __Community Shelter __Other

****

Housing payment type (Check):

__Own Housing __Rent Housing __Make No Payment for Housing __Other

Length of time at current address (Check): __1-2 Years __6-12 Months __Less than 6 months __More than 2 years

****

During the enrollment year was the family homeless? __Yes __No Family acquired housing during enrollment year? __Yes __No Family currently has means of transportation? __Yes __No

Do you need transportation to appointments? __Yes __No

****

Transportation Used (Circle One): __Private Vehicle (car, truck, van) - __Primary __Secondary

Friend's or relatives vehicle - __Primary __Secondary __Other - __Primary __Secondary

# of adults in Family? (Check) - __1 __2 __3 __4 __5 __5+

# of Adults Contributing to the Income? (Check) - __1 __2 __2+

# of children in Family? (Check) - __1 __2 __3 __4 __5 __5+

****

Referral Source (Check One Below): __Child Welfare Agency __Hospital/Health Clinic __Self Referral __Friends/Family __Outreach/Recruitment

Adult Information Box:

Expected Delivery Date: _____/_____/_____ Actual Delivery Date: ____/____/____

High Risk Pregnancy: __Yes __No Last Dental Exam: ____/____/____ First received prenatal care: ____/____/____ Last Prenatal Care Visit: ____/____/____

Postpartum Schedule date: ____/____/____ Postpartum actual date: ____/____/____

Prenatal Care Provider: _____ Provider Type: _____

Prenatal Health Care: __Yes __No Postpartum Health Care: __Yes __No Mental Health interventions and follow up: __Yes __No Substance abuse prevention: __Yes __No

Substance Abuse Treatment: __Yes __No Prenatal education on fetal developments: __Yes __No

Information on the benefits of breastfeeding: __Yes __No

Receiving services at time of birth: __Yes __No Infant enrolled in program after birth: __Yes __No

****

ABOUT YOUR INCOME:

This is required information: Please fill out completely and attach copies (not originals) *of forms that provide proof of your income. Proof of income can be presented through W-2 forms, Individual Tax Form 1040, pay stub/pay envelopes, current public assistance receipt* (notice of Action forms) *Written employers statement, Social Security, and/or forms that verify income from other sources* (child support, etc).

Types of Services or Financial Assistance Received (Check all boxes below that apply):

__Supplemental Security Income (SSI) __Foster Care/Adoption Subsidy __WIC

__Medical Financial Assistance (i.e, Medicaid/Medicare) __Child Support/Alimony

__No Services Received __Supplemental Nutrition Assistance Program (SNAP) aka Food Stamps

Are you currently receiving services through TANF, or have you in the past year? (Circle) Yes/No

Are you currently a foster parent of the child wishing to enroll in the Head Start/Early Head Start? (Circle): Yes/No

Are you currently receiving SSI or have been in the past year? (Circle): Yes/No

1. I declare under penalty of perjury that the information provided is true and correct to the best of my knowledge.
2. I will notify the agency immediately if there is any change in my income, family size, residence, employment, or reason for needing child support development services.
3. I understand that the information about my eligibility may be reviewed by representatives of the State of South Dakota/North Dakota, The Federal Government, independent auditors, or others as necessary for the administration of the program.
4. I understand that I will receive a notice of approval or disapproval of my eligibility application.

5. I understand that this certification is not complete until all documentation is submitted and this form has been reviewed, signed, dated by an agency representative and signed and dated by me.
6. I understand there is additional paperwork for me to fill out if my child is approved for Head Start/Early Head Start.

_____ _____/_____/_____
Applicant Signature Date

****

Health Insurance:

__Medicaid __Private Insurance __IHS __Other

Primary Doctor:_____ Primary Clinic:_____

Medicaid Number: _____

****

Active Military: __Yes __No Military Veteran __Yes __No

Referred by Child Welfare Agency: __Yes __No Receiving SNAP: __Yes __No

WIC: __Yes __No WIC ID#: _____

****

RACE:

__American Indian or Alaskan Native __Asian __Black African American __Multi-racial/Biracial

__Native Hawaiian/Other Pacific Islander __White __UnspecifiedHispanic/Latino: __Yes __No

****

FAMILY INCOME:

__W-2 __TANF __General Assistance __Paystub __SSI __Income Tax Form 1040/1040A

__Unemployment Letter __College Award Letter __Foster Care Reimbursement

__Written Statements from Employers/Lettter __Other

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To: **Social Service Agency and Employers**
From: **Standing Rock 0-5 Head Start**
RE: **Income Verification Statement**

The Head Start Program serves children from low-income families. In order for the child to be eligible for the Head Start Program, the Federal Guidelines require that parents/guardians provide an income verification statement. We would appreciate your help by completing the following income statement. This information will be kept confidential.

Parent/Guardian Signature: _____ Date: _____

AGENCY OFFICIAL/EMPLOYER:_____

I certify that _____
Received income from the following sources:

__BIA __General Assistance(GA) __Sitting Bull College __Sioux __Corson __Walworth
__Workforce Enforcement Act (WIA) __TANF

The amount this client received per month is as follows:

January	$_____	February	$_____	March	$_____
April	$_____	May	$_____	June	$_____
July	$_____	August	$_____	September	$_____
October	$_____	November	$_____	December	$_____

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Adult Medical Provider Information

Effective Date: ____/____/____ Name: _____

Completed By: __Head Start Specify: _____

__Medical Provider Specify: _____

Insurance Provider Type:

__Public Assistance (e.g., Medicaid, EPSDT or equivalent) __Private Coverage

__Child Health Program(CHIP) __Other: Specify _____

Primary Care Provider: __No regular primary care provider

Provider Name Phone #:

Street Suite #:

City State Zip

Dental Care Provider: __No primary Dentist

Provider Name Phone #:

Street Suite #:

City State Zip

Specialist Provider: __No Specialist

Provider Name Phone #:

Street Suite #:

City State Zip

Type of Services Received:

_____

_____

Has Secondary Insurance: __Yes __No

Secondary Insurance Information:

_____

_____

Pregnancy Outcome Tracking

Date Completed: ____/____/____ Name: _____

Completed By: __Head Start Staff Specify: _____

__Medical Provider Specify: _____

Pregnancy Outcome: __Live Birth __Spontaneous Abortion __Fetal Death/Stillborn

__Ectopic Pregnancy __Induced Abortion __Other

Outcome Date: ____/____/____ Maternal hospital discharge date: ____/____/____

(Live Birth Only)

Delivery location: __Hospital __Birthing Center __At Home __Other:_____

Delivery Type: __Vaginal __C-Section __

Plurality: __Singleton __Twin __Triplet __Quad or higher

Infant Outcome:

Child Name: _____
Birth Date: _____
Gender: _____
Birth Weight: _____
Birth Order: _____
Admitted to NICU/SCN: __Yes __No
Infant Died: __Yes __No

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Birth Date: _____
Gender: _____
Birth Weight: _____
Birth Order: _____
Admitted to NICU/SCN: __Yes __No
Infant Died: __Yes __No

Child Name: _____
Birth Date: _____
Gender: _____
Birth Weight: _____

Child Name: _____
Birth Date: _____
Gender: _____
Birth Weight: _____

Birth Order: _____ Birth Order: _____

Admitted to NICU/SCN: __Yes __No Admitted to NICU/SCN: __Yes __No

Infant Died: __Yes __No Infant Died: __Yes __No

Complications associated with this delivery:

__Pre-eclampsia/Eclampsia __Pre-term Labor __Premature membrane rupture

__Placenta Previa __Abruptio Placentae __Fetal Distress __Postpartum Hemorrhage

__Other: Specify _____ __None of the above

COMMENTS:

_____

_____

_____

_____

_____

_____

Information contained in this section will be used by HSFIS to establish a family member record for this child, the Demographics Form.

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Standing Rock 0-5 Head Start
2019-2020 School Year
Eligibility Verification

(Fort Staff Use Only)

1. Adults name: _____
2. Adults date of birth: _____
3. This adult is eligible to participate in the program __Yes __No
4. Check the applicable category of eligibility for this child:

__Income (check mark all that applies):
- __Below federal poverty guidelines
- __Between 100-130% of federal poverty guidelines
  (no more than 35% of enrolled children may fall into this category)

__Over-income
- __Counted as part of 10% maximum for non-AI/AN programs
- __Counted as part of the 49% maximum for AI/AN programs

__Public Assistance
__SSI
__Homeless
__Foster Care

5. What Documentation was used to determine eligibility?

__Income Tax form 1040
__W-2
__TANF Documentation
__Pay Stub or Pay Envelopes
__Unemployment
__Written statements from employers
__Foster Care Reimbursement
__SSI Documentation
__Other
If other, please explain: _____

Application date: ___/___/___ Start Date: ___/___/___

6. Staff signature: _____ Date of Eligibility: __/___/___
7. Staff name: _____ Title: _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 08-31-2020
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____, hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II. The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS	ADDRESS
CITY/STATE	CITY/STATE

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research ☐ Other *(Specify)* _____
☐ Personal Use ☐ Insurance ☐ Disability ☐ Health Information Exchange (IHS/Other _____)

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____

☐ Only the period of events from _____ to _____
☐ Other *(specify) (CHS, Billing, etc.)* _____
☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated. For Health Information Exchange authorizations, it is recommended to expire in at least five years.

_____
(Specify new date)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

NAME *(Last, First, MI)*	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH

Instructions for Completing IHS Form 810 --
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Print legibly in all fields using dark permanent ink.
2. Section I, print your name or the name of patient whose information is to be released.
3. Section II, print the name and address of the facility releasing the information. Also, provide the name of the person, facility, and address that will receive the information.
4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, research-related projects, etc. For an Health Information Exchange (HIE) other than IHS, please provide the name of the HIE.
5. Section IV, check the appropriate box as applicable.
   a. **Only information related to** -- specify diagnosis, injury, operations, special therapies, etc.
   b. **Only the period of events from** -- specify date range, e.g., Jan. 1, 2002, to Feb. 1, 2002.
   c. **Other *(specify)*** -- e.g., Purchased Referred Care (PRC), Billing, Employee Health.
   d. **Entire Record** -- complete record including, if authorized, the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes).
   e. **IN ORDER TO RELEASE SENSITIVE INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), THE APPROPRIATE BOX OR BOXES MUST BE CHECKED BY THE PATIENT.**
   f. **Psychotherapy Notes ONLY -- IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.**

      IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

      Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.
   g. When you opt-in to share information through the HIE, an expiration date must be entered.
6. Section V, if a different *expiration* date is desired, specify a new date. For HIE, a date 5 years in the future is recommended in order to provide health information for continuity of care.
7. Section V, Please sign (or mark) and date.
8. A copy of the completed IHS-810 form will be given to you.

OMB STATEMENT

Public reporting burden for this collection of information is estimated to average 10 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Indian Health Service, Office of Management Services, Division of Regulatory Affairs, Mail Stop 09E70, 5600 Fishers Lane, Rockville, MD 20857, RE: OMB No. 0917-0030. Please DO NOT SEND this form to this address.