Missouri Ozarks Community Action, Inc.
PO Box 69
Richland, MO 65556 1-800-876-3264

Intake Application
Head Start

Center Applying for: _____
☐ Early Head Start ☐ Head Start Full Day ☐ Head Start Part Day

Eligible Child/Pregnant Woman First Name MI Last Name	Date of Birth:	Gender: M / F	Primary Language:
Pregnant woman; Due Date: _____	Child; Previously enrolled? ☐ Yes ☐ No	Previously applied/on wait list? ☐ Yes ☐ No	
Adult #1: Head of Household First Name MI Last Name	Date of Birth:	Gender: M / F	Primary Language:

☐ Employed ☐ Unemployed ☐ Student
Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed
Relationship to Eligible Child/Pregnant Woman: ☐ Biological Parent ☐ Legal Guardian ☐ Step Parent ☐ Aunt/Uncle ☐ Foster Parent ☐ No Biological/Legal Relationship ☐ Spouse ☐ Grandparent

Adult #2: First Name MI Last Name	Date of Birth:	Gender: M / F	Primary Language:

☐ Employed ☐ Unemployed ☐ Student
Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed
Relationship to eligible child: ☐ Biological Parent ☐ Legal Guardian ☐ Step Parent ☐ Aunt/Uncle ☐ Foster Parent ☐ No Biological/Legal Relationship ☐ Grandparent

Names of other **family members** living in same household	Date of Birth	Gender	Relationship to Eligible Child/Pregnant Woman
		M / F	
		M / F	
		M / F	
		M / F	

Living Address ☐ *own* ☐ *rent*			Ph # 1 ( )	Type
City	State	Zip	Ph # 2 ( )	Type
Mailing Address ☐ *check if same as living address*			Ph # 3 ( )	Type
City	State	Zip	Ph # 4 ( )	Type

How did you hear about us?

Yes	No	**Health Assessment**		
		High Risk Pregnancy?	Enrolled in Prenatal Care? ☐ No ☐ Yes	Last exam date:_____
		IFSP/IEP for a Disability – must show proof of current IFSP/IEP		
		Established Risks: Down Syndrome, Fetal Alcohol Syndrome, Hearing/Vision Impairment, Medically Fragile		
		Biological/Medical Risks: central nervous system infection/trauma, congenital heart disease, failure to thrive; diabetes, severe chronic illness, sickle cell anemia, sibling with documented disabilities		
		Environmental Risks: mother < age 17 at birth of eligible child; mother's education < 8th grade; parental developmental disability; child abuse and/or neglect–documented, family social disorganization (non-foster home, non-parents)		
		Asthma ***if yes, is an inhaler required? Yes or No***		
		Seizures		
		Cardiac Abnormalities		
		Food Allergies; ***if yes, please list:***		***epi-pen? Yes or No***
		Environmental Allergies (i.e. pollen, latex, mold, dust) ***if yes, please list:***		***inhaler? Yes or No***
		Diabetes		
		Birth Defects		
		Any type of chronic illness		
		Physical Impairment		
		Hearing or Vision Loss		
		Has a doctor placed your child on a special diet?		
		Does your child take any Prescription medications? ***if yes, please list:***		
		Are there any other health issues or concerns that we need to be aware of?	_____ _____	
		Do we have your consent to contact the child's physician to clarify any health issues? *If no, no signature required.*		

Parent Signature:	Date	Name of Doctor	Phone Number:

Any "Yes" answers to <u>Child Health Issues</u> requires a copy of this page to be forwarded to MOCA Head Start Director of Health.

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Income Checklist

Eligible Child/Pregnant Woman: _____ Date: _____

Number of family members living in household:

Adults: _____

Children: _____

Family Size: _____

Do any family members in this household ***currently*** receive:

- ☐ TANF (Temporary Assistance for Needy Families)
- ☐ SSI (Supplemental Security Income)
- ☐ Foster Child
- ☐ Active Military Pay

if any above are checked, proper documentation of benefits must be presented

Please check all of the following that apply for the previous 12 months or calendar year:

Mother	Father	*for all items checked; documentation must be presented and included in total annual income*
		Full time job
		Part time job
		Self-employed
		Social Security or Railroad retirement; Disability payments
		Unemployment Compensation, strike benefits from union funds, worker's compensation,
		Veterans Benefits
		Emergency Assistance money payments
		Non-Federally funded General Assistance or General Relief money payments
		Training stipends
		Child Support or alimony
		Military family allotments or other regular support from an absent family member
		Private pensions; Government employee pensions (including military retirement pay)
		Regular insurance or annuity payments
		College or University scholarships; grants, fellowships, and assistantships
		Dividends, interest, net royalties, periodic receipts from estates or trusts
		Net gambling or lottery winnings
		Net rental income
		None of the Above *if this is checked, please complete a* **Verification form**

I certify that the information provided in the MOCA Head Start/Early Head Start application is true, complete and correct.

Parent/Guardian Signature: _____ Date: _____

Print Parent/Guardian Name: _____

AGENCY USE ONLY

Age Documentation: (check one)

- ☐ **Birth Certificate**
- ☐ **Medicaid Card**
- ☐ **Public Assistance form**
- ☐ **Other:**_____

Immunization Record received: ☐ **Yes** ☐ **No**

Income Documentation: (check one)

- ☐ **Tax Form/W2**
- ☐ **Pay Stub**
- ☐ **Employment Letter**
- ☐ **Unemployment**
- ☐ **Other:** _____
- ☐ **TANF Award Letter**
- ☐ **SSI Award Letter**
- ☐ **Foster Care**
- ☐ **Documentation of No Income**

Income Eligible:
☐ **Below federal poverty guidelines** ☐ **SSI** ☐ **TANF** ☐ **Foster** ☐ **Homeless**

Over Income:
☐ **100%-130%** ☐ **Over 130%**

In accordance with Head Start Performance Standard 45 CFR 1302.12(k)(ii)(iii) I have completed an in-person interview, examined the age and income documentation indicated, and have verified this child/pregnant woman is eligible to participate in the MOCA Head Start/Early Head Start program.

_____ _____
Staff Signature **Date**

_____ _____
Central Office Verification **Date**

Adult #1: Head of Household: _____

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Family Assessment

Yes	No		Yes	No	
		Do you spend too much on Utilities?			Are you currently facing any emergencies?
		Do you wish your housing situation could be improved?			Do you need assistance with childcare?
		Do you need more food?			Do you need transportation assistance?
		Are you dissatisfied with your employment/education situation?			Do you receive food stamps?
		Do you or your family have any health issues?			Do you receive Child Support?

Family member first name	Education level Last grade completed	Insurance Medicaid/Medicare/Private/None	Race	Check box if:		
				Hispanic/Latino	Disabled	Veteran

Check if you receive the following ☐ SNAP/food stamps ☐ WIC ☐ TANF ☐ Rental Assistance ☐ Section 8 ☐ Earned Income Tax Credit

CLIENT CONFIDENTIALITY AGREEMENT/RELEASE OF INFORMATION

I certify that the information given on this application is true and accurate to the best of my knowledge and belief. I understand that such information is subject to verification and I further realize that falsified or fraudulent information may result in the rejection of this application.

Under the terms of this Agreement, CLIENT agrees to release to MOCA information that is confidential and proprietary to CLIENT (Confidential Information), to be used solely for the Agency's related statistics, services and programs. – Confidential Information refers to any and all information of a confidential, proprietary, or secret nature which is or may be related in any way to the family, medical records, job history, present or future, of CLIENT or any related data. Confidential Information includes, for example, but not limited to: spouses or other family members, ages, salaries, financial standings, criminal records, medical records and all other pertaining to the family information. MOCA will consider all information received from CLIENT to be strictly confidential, as required by the Privacy Act, and subject to the restrictions of this Agreement; except for information that is:

(i) generally known to the public;
(ii) in possession of MOCA before receipt from CLIENT;
(iii) obtained later by the Agency from a third party without restriction or violation of Agreements.

MOCA will not disclose CLIENT's Confidential Information to any other party without the prior written consent of CLIENT. MOCA may, however, disclose Confidential Information to its employees and/or programs but only if the employee has a legitimate need to know and has agreed to terms similar to those in the Agreement. Community Action Agency may also disclose this Confidential Information

(i) to medical personnel in an emergency;
(ii) to qualified personnel for research, audits, or program evaluation, as long as CLIENT identities are not identified;
(iii) to a third party based on court orders; and
(iv) to appropriate authorities in cases of suspected child abuse or neglect. MOCA will be responsible for any use or disclosure of Confidential Information by any of its employees or agents to third parties who should not share this information.

This Agreement may be amended only in writing and shall be governed by the laws of the State of Missouri.

Please sign below to indicate that you have read this Consent and agree with its terms.

_____ _____
CLIENT Signature Date

_____ _____
Interviewer's Signature: Date