JEFFERSON COUNTY HEAD START

serving Jefferson, Clear Creek, Gilpin, and Park counties

APPLICATION INSTRUCTIONS

Please return the following documents to the center nearest you:

☐ **Application**

☐ **State Certified Birth Certificate**

☐ **Proof of Jefferson County Residency - Excluding city of Lakewood**
(Please provide ONE of the following documents)
Utility bill, lease, mortgage statement, SSI verification, Food Stamp or TANF verification with parent/guardian name and address.

☐ **Income Verification for the year 2013** or the previous 12 months from the date of application.
Preferred forms of documentation:

- Public Assistance Verification Letter (TANF or SSI)
- 1040 Tax Form or W-2 Forms
- Homelessness verification – Letter from shelter, letter from family member(s), etc.
- Foster verification

Additional Verification: (If you do not have the preferred documentation)

- 12 months of pay stubs from employer
- Verified letter from employer (must be on company letter head and or include employer contact info)
- Award letter from College or University – Scholarship, grant, or fellowship
- Child Support – Court document or verified letter

☐ **Immunization Records:** Must be signed by authorized medical personnel. ***Must be attained from family before the child can start according to Child Care licensing rules for the State of Colorado.***

☐ **Physical Exam Report:** Please have physician complete Head Start physical form. ***Please bring to your enrollment appointment. Due on or before the first day of school.***

☐ **Dental Exam Report**: Please have dentist complete Head Start dental form. ***Please bring to your enrollment appointment. Due on or before the first day of school.***

☐ **Copy of child's Medicaid Card** (if applicable)

Please Note:
We will do our best to place your child in the classroom of choice. Please select your preferences on the application.

Please mail or drop off your application to the center nearest you.
5150 Allison St. Arvada, CO 80002
Phone720-497-7900, Fax 720-898-0664
Or
12725 W. 42nd Ave. Wheat Ridge CO, 80033
Phone 720-497-7680, Fax 303-423-8507

**** If you need help in getting any of the above documents, or if you have questions, please contact us.**
We can help you with copies if needed.

Visit us @ http://jeffco.us/head/
Thank you for applying to Jefferson County Head Start!

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APLICACIÓN DE INSCRIPCIÓN

Favor de devolver los documentos al centro más cercano a usted:

□ **Aplicación**

□ **Certificado de Nacimiento – Certificadas por el estado.**

□ **Prueba de la dirección de su residencia en el Condado de Jefferson – Excluyendo la ciudad de Lakewood** (Por favor provea UNO de los siguientes documentos) Recibo de las utilidades, renta, hipoteca, verificación del SSI (Seguro para Discapacitados), Asistencia de Alimentos ó TANF (Ayuda Temporera a Familias Necesitadas) **que tenga el nombre del padre/madre/guardián y su dirección de domicilio.**

□ **Verificación de Ingresos para el año 2013** o de los 12 meses anteriores a la fecha de la aplicación.
Formas preferidas de documentación:

- Carta de Verificación de asistencia pública (TANF o SSI)
- Forma de Taxes 1040 o W-2.
- Verificación de que no tiene casa-Carta del refugio, carta de un miembro de la familia, etc.
- Verificación de hogar adoptivo

Verificaciones adicionales: (Si usted no provee la documentación recomendada)

- Talones de los últimos 12 meses de empleo.
- Una carta escrita por su empresario (patrón) que verifique su empleo. (debe ser en una carta de la compañía y/o que incluya la información de contacto del empleador)
- Carta o Certificado de Universidad o Colegio - Beca, ayudantía.
- Pensión Alimenticia – Documento de la corte o carta verificada (notarizada).

□ **Récord o Tarjeta de Vacunas del niño/a.** Tarjeta de Vacunas de Colorado (Firmada por personal médico) ***Tiene que ser entregado por la familia antes para que el niño pueda comenzar. De acuerdo a las reglas que otorgan la licencia para el cuidado de niños en el estado de Colorado.***

□ **Reporte de Exámen Físico.** Un médico completará la forma del examen físico de Head Start. ***Por favor haga su cita de matricula antes del primer día de escuela.***

□ **Reporte de Exámen Dental.** Un dentista completará la forma para el examen dental de Head Start. ***Por favor haga su cita de matricula antes del primer día de escuela.***

□ **Copia de la tarjeta de Medicaid del niño** (si aplica).

Nota importante:
Haremos nuestro mayor esfuerzo para colocar a su hijo en el aula de la elección. Por favor seleccione sus preferencias en la aplicación.

Favor de entregar su aplicación a su centro más cercano.

5150 Allison St. Arvada, CO 80002
Phone720-497-7900, Fax720-898-0664
O
12725 W. 42nd Ave. Wheat Ridge CO, 80033
Phone720-497-7680, Fax303-423-8507

**** Si necesita ayuda con alguno de los documentos mencionados o si tiene alguna pregunta por favor póngase en contacto con nosotros. Nosotros le podemos ayudar con las copias si es necesario.**

Visítenos en nuestra página web: http://jeffco.us/head/
! Gracias por aplicar al Head Start del Condado de Jefferson!

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ENROLLMENT APPLICATION

(If you have questions or need assistance filling out this application, please contact the center nearest you. This application is also available in Spanish and can be made available in any other language.)

I would like to apply for: (Check all that apply)	
□ Arvada Center 5150 Allison St. Arvada, CO 80003 720-497-7900 □ AM □ PM □ Either □ Full Day	□ Wheat Ridge Center 12725 W. 42nd Ave. Wheat Ridge, CO 80033 720-497-7680 □ AM □ PM □ Either

Child & Family Information

Child's First Name	Middle Name	Last Name	Date of Birth	Gender (Please circle) M F	Language spoken at home Primary: Secondary:

Who has Custody of Child? □ Mother □ Father □ Both □ Other (Specify:_____)
Child lives with: _____

Hispanic: □ Yes □ No **Race:** (Check all that apply) □ American Indian or Alaska Native □ Asian □ Black or African American □ Multi-Racial/Bi-Racial □ Native Hawaiian/Other Pacific Islander □ White □ Other: _____	**Health Insurance:** Insurance Provider: _____ (Medicaid, CHP+, Private, etc.) Insurance Number: _____ □ Pending □ None	**To Your knowledge does your child have any of the following?** □ IEP (Individualized Education Plan) □ IFSP (Individualized Family Service Plan) □ Doctor's diagnosis: _____ If YES, please name the agency providing services to your child. _____

Is your child RECEIVING SERVICES for, or WOULD YOU LIKE your child to receive services for, any of the following?		
□ Allergies (Please specify) _____	□ Emotional/Behavioral Concerns	□ Learning Disability
□ Asthma	□ Food Restrictions (Please specify) _____	□ Speech/Language Impairment
□ Autism	□ Health Concerns (Please specify) _____	□ Visual Impairment/Glasses
□ Developmental Delay	□ Hearing Impairment	□ Other (Please specify) _____

Please check all services your FAMILY is currently receiving:		
□ Involved with Child Welfare or Child protection	□ WIC (ID #_____)	□ Social Security
□ SNAP (Food Stamps/Assistance)	□ CCAP (Child Care Assistance Program)	□ Domestic Violence Services
□ TANF (Current or Former)	□ Public Housing (Section 8, Subsidized, etc.)	□ Other (Please Specify) _____
□ SSI (Supplemental Security Income)	□ Child Support	□ NONE

I was referred to Head Start By:
□ Child Welfare Agency (Children Youth & Families, Kinship Care, etc.) □ Friend/Family □ Other (Please specify) _____
Do you need assistance with transporting your child to and from school? □ **Yes (Please explain below)**
(Explain) _____

Priority Score: The following info will help us give your child priority into the program. (Please check all that apply)		
□ Foster child or Kinship Care child	□ Teen Parent (When child was born)	□ Incarcerated Parent-Current or Former
□ Homeless ** **(Living in shelter, Vehicle, hotel/motel, etc.)**	□ Involved with social services (Child welfare or child protection)	□ Currently unemployed due to lay off in past 12 months
□ Homeless ** (Living with **RELATIVE/FRIEND** due to economic hardship)	□ Chronic/Severe Medical Condition (ex: Cancer, MS, Clinical Depression, etc.)	□ Military Family/Veteran
□ Domestic Violence- Current or Former	□ Returning or Transferring Head Start Child	□ Currently pregnant
□ History of or current drug or alcohol abuse in family	□ Sibling in Head Start - Current	□ Transportation services needed

PARENTAL STATUS: (In the home) □ One Parent □ Two Parent □ Foster □ Legal Guardian □ Grandparent/Relative	**TOTAL** # of Family Members: _____ # of Adults in Family _____# of Children in Family _____

Family Information

Primary Adult/Guardian First Name	Last Name	Date of Birth	Gender (Please circle) M F	Relationship to Head Start child	Language Spoken at home
					Primary: Secondary:

Lives with child? □ YES □ NO **Shared or Visitation?** □ YES □ NO **Provides financial support to the family?** □ YES □ NO

LIVING ADDRESS:

_____

(Street Address) (City) (Zip)

□ **My own Residence** □ **Living with Relative/Friends** □ **Other** _____

MAILING ADDRESS: (If different than living address)

_____

(Street Address) (City) (Zip)

PHONE NUMBERS & EMAIL:

Home: _____ **Cell:**_____ **Work:**_____ **Other:**_____

EMAIL:

Hispanic: □ Yes □ No

Race: (Check all that apply)
□ American Indian or Alaska Native □ Asian □ Black or African American □ Multi-Racial/Bi-Racial □ Native Hawaiian/Other Pacific Islander □ White
□ Other: _____

Highest grade completed in school: (check all that apply)
□ Grade 9 or less □ Grade 10 □ Grade 11 □ Grade 12 □ GED □ High School Graduate □ College Degree/Training Cert. □ College or Advanced Training
□ Associate's Degree □ Bachelor's Degree □ Master's Degree (or above)

Employment Status: (check all that apply)
□ Full time Work & Training □ Full time Work (35hrs/week or more) □ Part time Work & Training □ Part Time Work (Under 35hrs/week)
□ Retired or Disabled □ Seasonally Employed □ Training or School □ Unemployed (looking for employment) □ Not Employed (stay at home)

Secondary Adult/Guardian First Name	Last Name	Date of Birth	Gender (Please circle) M F	Relationship to Head Start child	Language Spoken at home
					Primary: Secondary:

Lives with child? □ YES □ NO **Shared or Visitation?** □ YES □ NO **Provides financial support to the family?** □ YES □ NO

LIVING ADDRESS:

_____

(Street Address) (City) (Zip)

□ **My own Residence** □ **Living with Relative/Friends** □ **Other** _____

MAILING ADDRESS: (If different than living address)

_____

(Street Address) (City) (Zip)

PHONE NUMBERS & EMAIL:

Home: _____ **Cell:**_____ **Work:**_____ **Other:**_____

EMAIL:

Hispanic: □ Yes □ No

Race: (Check all that apply)
□ American Indian or Alaska Native □ Asian □ Black or African American □ Multi-Racial/Bi-Racial □ Native Hawaiian/Other Pacific Islander □ White
□ Other: _____

Highest grade completed in school: (check all that apply)
□ Grade 9 or less □ Grade 10 □ Grade 11 □ Grade 12 □ GED □ High School Graduate □ College Degree/Training Cert. □ College or Advanced Training
□ Associate's Degree □ Bachelor's Degree □ Master's Degree (or above)

Employment Status: (check all that apply)
□ Full time Work & Training □ Full time Work (35hrs/week or more) □ Part time Work & Training □ Part Time Work (Under 35hrs/week)
□ Retired or Disabled □ Seasonally Employed □ Training or School □ Unemployed (looking for employment) □ Not Employed (stay at home)

Other Family Members Supported by Primary Adult. **(Excluding the child you are enrolling into Head Start)**

Adult/Child (Please circle)	Gender (Please circle)	First Name	Last Name	Date of Birth	Relationship to Head Start child
Adult Child	M F				
Adult Child	M F				
Adult Child	M F				
Adult Child	M F				
Adult Child	M F				

I certify that the information provided in this form is accurate and truthful to the best of my knowledge.
Jefferson County does not discriminate on the basis of race, color, national origin, sex, religion, age or disability in the provision of services.

Parent Signature: _____ **Date** _____

Please fill out both sides of this form.

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CONSENT TO EXCHANGE HEALTH INFORMATION

Child's Name: _____ Child's Date of Birth: _____
Parent(s)/Guardian's Name: _____
Address: _____ City: _____ Zip: _____
Phone # (H): _____ (W): _____
Primary Language: _____ Family Interpreter: _____

As parent/guardian of the above named child, I authorize the mutual exchange of confidential information between Jefferson County Head Start and:

□ Arvada Pediatrics 8030 Lee Drive Arvada 80005
Phone: (303) 421-6873 Fax: (303) 421-9922
□ Carin Clinic 5150 Allison Street Arvada 80002
Phone: (303) 423-8836 Fax: (303) 403-0592
□ Clinica Campesina Location: _____
□ MCPN Location: _____
□ Rocky Mountain Pediatrics 2020 Wadsworth Blvd #16 Lakewood 80215
Phone: (303) 233-8701 Fax: (303) 233-2850
□ Rocky Mountain Youth Clinics 9195 Grant Street #301 Thornton 80229
Phone: (303) 450-3690 Fax: (303) 450-3699
□ Peak Pediatrics 3555 Lutheran Pkway #340/#370 Wheat Ridge 80033
Phone: (303) 996-6005 Fax: (303) 420-8831
□ Pediatrics West 3555 Lutheran Pkway #200 Wheat Ridge 80033
Phone: (720) 284-3700 Fax: (303) 467-0525
□ Other: _____

Information to be Released:
□ Physical Exam form □ Immunization Record
□ Special Diet Statement □ Other _____

Reason for exchange of information:
□ Head Start Requirement □ Other _____
□ Collaboration of Services

_____ _____
Parent(s)/Guardian(s) Signature/Date Head Start Staff Signature/Date

In accordance with the requirements of the **Family Education Rights and Privacy Act (FERPA),** and the **Jefferson County Head Start Confidentiality Policy**, information sent or received by Head Start may not be shared with any other party without the written consent of the parent(s) or guardians(s).

*****This consent form will expire one year from date signed.*****

**IF THIS IS FOR AN EXISTING FAMILY GOAL, PLEASE CONTACT JEFFERSON COUNTY HEAD START TO ENSURE THE DELIVERY OF SERVICES TO THE FAMILY IS MUTUALLY SHARED.

Please fill out both sides of this form.

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CONSENT TO EXCHANGE HEALTH INFORMATION

Child's Name: _____ Child's Date of Birth: _____
Parent(s)/Guardian's Name: _____
Address: _____ City: _____ Zip: _____
Phone # (H): _____ (W): _____
Primary Language: _____ Family Interpreter: _____

As parent/guardian of the above named child, I authorize the mutual exchange of confidential information between Jefferson County Head Start and:

□ All About Kids Dental 2020 Wadsworth Blvd Arvada 80214
Phone: (303) 431-1221 Fax: (303) 463-0792
□ Comfort Kids Dentistry 9990 W. 26th Ave. Garden Level Lakewood 80215
Phone: (720) 285-7972 Fax: 1-877-444-4055 (3 other locations)
□ Kid Focus Dentistry 5111 Kipling St Wheat Ridge 80033
Phone: (303) 543-8338 Fax: (720) 382-1289
□ MCPN Dental Clinic 11005 Ralston Road Ste100G Arvada 80004
Phone: (303) 431-0844 Fax: (303) 456-6124
□ Pediatric Dental Group 7975 Allison Way Arvada 80005
Phone: (303) 421-5437 Fax: (303) 422-5300
□ Pediatric Dental Group 8500 W 38th Ave #306 Wheat Ridge 80033
Phone: (303) 467-8888 Fax: (303) 467-8801
□ Primary Dental 5801 W. 44th Ave. # C Denver 80212
Phone: (303)433-1239 Fax: (303) 455-5317
□ Other: _____

Information to be Released:
□ Dental Exam Form □ Other _____

Reason for exchange of information:
□ Head Start Enrollment Requirement □ Other _____
□ Collaboration of Services

_____ _____
Parent(s)/Guardian(s) Signature/Date Head Start Staff Signature/Date

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PHYSICAL EXAMINATION

PARENT TO COMPLETE	CHILD'S NAME:	CENTER/CLASS:	BIRTHDATE:
	Illnesses/Accidents/Problems/Concerns since last visit:	Today I have a question about:	

TO BE COMPLETED BY HEALTH CARE PROVIDER

Allergies:	Current Medications:

Temp _____	Pulse _____	BP_____/_____	Height _____%_____	Weight _____%_____	BMI _____

Head Start must follow Colorado State EPSDT standards. If blood lead level was done at 9-12 & 24 months and HGB/HCT was done before this exam, we can use those results.

Screening Test	Performed	Result(s)		Date
HGB/HCT	□ Yes □ No	_____ gm/dl _____ %	□ Normal □ Abnormal	
Lead Test Risk: □ Yes □ No	□ Yes □ No	_____ mcg/dL	□ Normal □ Abnormal	
TB Skin Test Risk: □ Yes □ No	□ Yes □ No	□ Positive □ Negative		

Screenings:

Hearing Screen

MHZ	R	L
4000	_____	_____
2000	_____	_____
1000	_____	_____
500	_____	_____

Vision Screen 20/_____ 20/_____

Development: Circle any areas of concern

Adaptive/Cognitive Language/Communication

Gross Motor Social/Emotional Fine Motor

	N	A	
Behavior	□	□	_____
Mental Health	□	□	_____

Physical:	N	A		N	A
General appearance	□	□	Chest	□	□
Skin	□	□	Lungs	□	□
Head	□	□	Cardiovascular/Pulses	□	□
Eyes (Cover/Uncover)	□	□	Abdomen	□	□
Ears	□	□	Genitalia	□	□
Nose	□	□	Spine	□	□
Oropharynx/Teeth	□	□	Extremities	□	□
Neck	□	□	Neurologic	□	□
Nodes	□	□	Gait	□	□

Describe abnormal findings and comments:

_____

_____

_____

Child Health History:

History of birth injury, abnormal growth/development, congenital defects? _____

_____

Significant acute or chronic medical problems? _____

_____

Significant behavior/emotional concerns?_____

_____

Special diet requirements? _____

_____

Any concerns regarding child's growth or weight?_____

_____

Do the child's activities need to be modified because of the above or other circumstances?_____

_____

Immunizations given today: _____

Immunizations completely up to date for age: □ Yes □ No

If no, please describe plans to bring child up to date:

_____

_____

A signed Colorado Certificate of Immunization must be submitted to Jefferson County Head Start with this evaluation.

_____ (initial) **I hereby certify that the above named child is in good health and is of normal physical and emotional maturity for age except as already noted. The child may fully participate in the program.**

_____ (initial) **I hereby certify that the above named child is up to date on their schedule of required EPSDT screenings.**

SIGNATURE OF HEALTH CARE PROVIDER:

NAME OF CLINIC/OFFICE (PLEASE PRINT):

PHONE NUMBER:

EXAM DATE:	**NEXT EXAM:**	**IS THIS THE CHILD'S MEDICAL HOME? □ YES □ NO**

Return Fax: 720-898-0664

PHYSICIANS

PLEASE READ

Head Start Federal Performance Standards mandate that certain medical tests are done that you may not do on a regular basis at yearly physicals. ***All of our students are required to follow the EPSDT standards for Medicaid regardless of insurance type.***
These tests include a

- **Hematocrit or Hemoglobin** at ages 3 & 4-5
- **Tb test** for high- risk populations (determined by the physician).
- **Lead test** – CMS (Centers for Medicare & Medicaid Services) requires that "all Medicaid-eligible children receive a screening blood test at **12 months and 24 months** of age. Children between the ages of **36 to 72 months** must also have a screening blood test *if a lead toxicity screening has not been previously conducted.* For cases where a blood "finger stick" test result is equal to or greater than 10ug/dL, the result must be confirmed through a venous blood draw". Please provide us with the results of any previous lead tests.

Please assist us in assuring that your patients get these tests completed at their physicals so that they do not have to schedule an extra visit.

Thank you,

Lauren Bell RN, BSN
Nurse Consultant
Jefferson County Head Start

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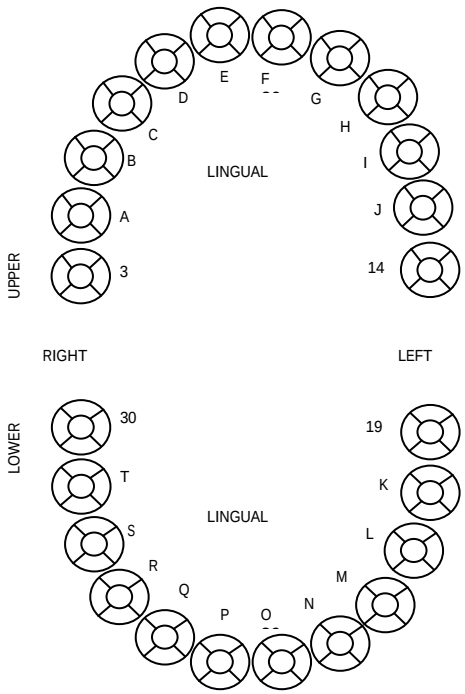
DENTAL HEALTH EVALUATION

CHILD'S NAME:	BIRTHDATE:	CENTER/CLASS:

Date of Exam: _____ **Routine Exam □** **Follow Up Treatment □** **Primary Dental Home □ YES □ NO**



Preventative care Received today: **Comments:**
- □ Cleaning
- □ Fluoride Application
- □ Sealants

Oral Health Status: **Comments:**
- □ No Oral health disease
- □ Active oral health disease
  - □ Cavities (#_____)

Treatment Received Today: **Comments:**
- □ Restoration(#_____)
- □ Extraction (#_____)
- □ All restorative treatment completed

Treatment Needed at Next Visit:
- □ No treatment needed, recall in 6 months
- □ Preventative Care (ex. Sealants)
- □ Restoration
- □ Extraction

Approximate number of visits needed: (#_____)
Date of next appointment: _____

Referrals:
- □ Needs referral to pediatric dentist
- □ Needs treatment under general anesthesia
- □ Needs referral to other dental specialist

Referred to:
Name: _____Phone Number: _____Appointment Date: _____

Signature of Provider: _____ Printed Name: _____Date: _____

Address: _____ Phone: _____ Fax: _____

Return Fax: 720-898-0664