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)
Standing Rock 0-5
Head Start Program

2020-2021 School Year
Prenatal Enrollment Information

Center Applying for: _____ Home Base

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

ELIGIBLE PREGNATAL 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  __Unspecified Hispanic/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
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 $_________
Standing Rock 0-5
Head Start Program

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

Street

City State Zip

Phone #:

Dental Care Provider: ___No primary Dentist

Provider Name

Street

City State Zip

Phone #:

Specialist Provider: ___No Specialist

Provider Name

Street

City State Zip

Phone #:
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
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.*
Standing Rock 0-5 Head Start Program

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

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

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

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(1)(3)).

PATIENT IDENTIFICATION

NAME (Last, First, MI) RECORD NUMBER

ADDRESS

CITY/STATE DATE OF BIRTH
Instructions for Completing IHS Form 810 --
AUTHORIZED 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.
   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.

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**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.