



Dear Family,

Thank you for your interest in the Head Start Child Development Program. Please complete both sides of the attached application, the health history and nutrition forms and return them to us with the following:

- **Recent proof of your family's income** (Cash Grant Action Notice or Passport to Services from Social Services, pay stubs **for one whole month**, Social Security payment notice, written verification from your employer or person providing for you at this time, your most recent W-2 or Tax return).
- **Proof of your child's age** (*birth certificate, DSS Passport to Services, Baptismal Certificate, Medi-Cal Card*)
- **Copy of your child's up-to-date immunization record**. California law states that children cannot attend school without proof of up-to date immunizations.

(Note: Your child's application will not be processed without these documents or if immunizations are not up to date)

- **We welcome children with special needs, food allergies and other medical conditions. Please note that additional follow up may be requested from agencies and/or medical providers currently working with your child in order to ensure that the program meets your child's needs.**

We use a point system that gives selection priority in certain situations, so it is important to answer each question on the application, sign and date it, and return it by email to npadilla@ncoinc.org, or by fax at 707-462-4792, or in person to any of our locations (see attached list), or by mail to our Central Office, at 550 North State Street in Ukiah. If you have questions about the application, need help in returning it, or would like copies made of your documents, please call us at (707) 462-2582.

After processing your application, we will send a letter about your child's application status. **Please note your application will only be considered for the program year you are applying for.**

Thank you for choosing the NCO Head Start Child Development Program as part of your child's early learning experience. We look forward to meeting you and your child.

Sincerely,
Head Start Enrollment Team

**Please call us with any questions at (707) 462-2582
or from outside Ukiah at 1-800-326-3122**

We invest in people through community action.



**NCO HEAD START
CHILD DEVELOPMENT PROGRAM**
Site Locations

Head Start centers serve children ages 3-5.
Early Head Start centers serve infants and toddlers.
Early Head Start Home Based serves infants, toddlers and pregnant mothers.

LAKE COUNTY

Upper Lake Head Start & State Preschool

Upper Lake Grammar School
629 2nd St.
Upper Lake Ca. 95485
707 275-2721

Lakeport Head Start

Located in Vista Point Shopping Center
864 Lakeport Blvd.
Lakeport Ca. 95453
707 263-8213

Meadowbrook Head Start & State Preschool

6958 Meadowbrook Dr.
Clearlake Ca. 95422
707 994-0854

Pearl Head Start

Clearlake Methodist Church-United
14521 Pearl Ave.
Clearlake Ca. 95422
707 994-6045

For Early Head Start services in Lake County contact Lake County Resource Center at (888)775-8336.

MENDOCINO COUNTY

North Ukiah Head Start

Next to Frank Zeek Elementary School
1100 N. Bush St.
Ukiah Ca. 95482
707 463-1354

South Ukiah Head Start

Across from Crossroads Christian Church
2161 S. State St.
Ukiah Ca. 95482
707 462-0253

Peach Tree Head Start, State Preschool & EHS Center

Across from DMV
425A S. Orchard Ave.
Ukiah Ca. 95482
707 463-8600

Nokomis Head Start, State Preschool & Early Head Start

On the west corner of Nokomis Elementary School
499 Washington Ave.
Ukiah Ca. 95482
707 462-2671

Willits Head Start

Brookside Elementary School
Spruce and Lincoln Way
Willits Ca. 95490
707 459-5141

Willits Early Head Start

Brookside Elementary School
Spruce and Lincoln Way
Willits Ca. 95490
707 459-1457

Fort Bragg Head Start

Redwood Elementary School
330 S. Lincoln St.
Fort Bragg Ca. 95437
707 964-5961

Mendocino County Home Based

550 N. State St.
Ukiah Ca. 95482
707 462-2582

NCO HSCDP Central Office

462-2582 (from Ukiah area)
or (800) 326-3122



We are happy to help you with this application at the Central Office or your local site – just ask!

NCO Head Start Child Development Program

HEAD START/EARLY HEAD START

Application

Central Office:
550 N. State St, Ukiah CA 95482
(707) 462-2582 or 1 (800) 326-3122
Fax (707) 462-4792

Please complete a separate application for each child.

1. <input type="checkbox"/> One parent living in home (<i>if single answer # 2</i>) <input type="checkbox"/> Two parents living in home <input type="checkbox"/> Foster parent - <i>If yes please attach proof.</i> <input type="checkbox"/> Temporary guardianship - <i>If yes please attach proof.</i>	2. <i>If single parent do you have shared custody?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>- If yes please attach proof.</i>
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Child's Name (applicant)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date	Child's Primary Language
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Child's Race: Pacific Islander Black White Biracial/Multi Hispanic Native American Asian

Does your child have an open case with Child Protective Services? Yes No

Name and phone number of Caseworker _____ () _____

Is your child enrolled in the Young Parent Program? Yes No

WE WELCOME CHILDREN WITH SPECIAL NEEDS

Child's Disability Status: None Diagnosed (*attach proof*) Suspected by Professional (*attach proof*)
 Parent Concern Please Explain: _____

Mother/Guardian Name <i>lives in home: <input type="checkbox"/> Yes <input type="checkbox"/> No</i>	Father/Guardian Name <i>lives in home: <input type="checkbox"/> Yes <input type="checkbox"/> No</i>
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Current employment status:	Current employment status:
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Highest education completed:	Highest education completed:
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E-mail address (required)	E-mail address (required)
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Race: <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Biracial/Multi <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Asian	Race: <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Biracial/Multi <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Asian
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Address	City	Zip Code
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Mailing Address (if different from above)	City	Zip Code
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Phone Numbers:	Home # ()	Cell# ()	Work# ()	Message# ()
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What is the best way to contact you: Home Phone Cell Phone **opt in for messaging** E-mail Mail

Preferred oral language: English Spanish ASL Other: _____
Preferred written language: English Spanish Other: _____

Do you currently receive? Cash-aid - *If yes please attach proof.* SSI - *If yes please attach proof.*
 Food Stamps WIC

Are you or your child related to anyone employed by NCO Head Start Child Development Program? YES NO

If yes: _____ (Name) _____ (Relationship)

List other children living in the home that are related to parent by blood, marriage or adoption:

Child's Name	Date of Birth	Sex	Relation to Child (Applicant)
1.		<input type="checkbox"/> Male <input type="checkbox"/> Female	
2.		<input type="checkbox"/> Male <input type="checkbox"/> Female	
3.		<input type="checkbox"/> Male <input type="checkbox"/> Female	
4.		<input type="checkbox"/> Male <input type="checkbox"/> Female	

Are any of the above children currently enrolled in Head Start or Early Head Start? Yes No

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Put a check mark (✓) in the box of any and all situations that currently apply to your family:

Does your family live in any of these situations?

- Living with friends or relatives **temporarily.**
- Living in a shelter.
- Living in a hotel or motel.
- Living in cars, parks, camp grounds, public spaces, abandoned buildings or substandard housing.
- Other (please explain): _____

Child has been served in another Head Start/EHS Program

Child is transitioning from Lake Family Resource Center (EHS)

Loss in family due to recent:

- separation
- divorce
- death

- Parent(s)/Guardian(s) currently attending ESL, Literacy Program, School or job training
- Teen parent
- Under 17 at birth of first child
- Parent(s) incarcerated
- Parent(s) in a recovery program for substance abuse
- Parent(s)/Guardian(s) has a severe disability, is seriously ill or has a high risk pregnancy.

Formal written referral from another agency or professional attached:

Name: _____

Change in family structure due to recent:

- blended family
- birth of baby
- deployment
- adoption

Custody of grandparent or relative (**attach proof**)

Is your child receiving specialized services from other agencies? Yes No

Agency Name(s): _____

Check below for the classes you are interested in:

HEAD START (PRESCHOOL)

Classes for 3-5 years old

Fort Bragg School Day (8am - 2pm)

Ukiah North Ukiah School Day (8am -2pm) South Ukiah School Day (8am - 2pm) A.M (8 - 12)
 Nokomis School Day (8am -2pm) Peach Tree Full Day (8am - 4pm) School Day (8am - 2pm)

Willits School Day (8am - 2pm)

Upper Lake School Day (8am - 2pm)

Lakeport School Day (8am - 2pm)

Clearlake Pearl A.M (8 - 12) P.M (12:30 - 4:30) Meadowbrook School Day (8am - 2pm)

EARLY HEAD START (Infants, toddlers & Pregnant mothers)

Ukiah Nokomis Center (**Only for Toddlers over 24 months**) Peach Center (**Toddlers over 18 months until 3 yrs.**)

Willits Willits Center (**Infants and Toddlers**)

Mendocino County Home Based (**Pregnant mothers and 0-3 years old**)

The HSCDP does not discriminate on the basis of gender, sexual orientation, ethnic group identification, race, ancestry, national origin, religion, color, mental or physical disability, or immigration status in determining which children are served.

I certify this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand the information in this application will be held in strict confidence within the agency and is accessible to me during business hours. This information will not be released without my written consent.

Parent/Guardian Signature: _____ Date: _____



HEALTH HISTORY AND PARENT MEDICAL AUTHORIZATION

CHILD'S NAME:		DATE OF BIRTH:	
PARENT NAME:			
ADDRESS:		City	Zip Code
PHONE:	HOME	WORK	CELL
			MESSAGE
SITE:		CLASSROOM:	

HEALTH AND DENTAL CARE	
Name of Child's Doctor (or clinic):	Name of Child's Dentist (or clinic):
Medical Insurance:	Dental Insurance:

RELEASE OF MEDICAL INFORMATION:

I agree to the release of medical information between Head Start Child Development Program and my child's Medical Providers, Dental Providers, the local Health Department and the WIC program for the purposes of coordination to provide the best possible health services to my child, and to meet the requirements for documentation of such services of the Head Start Child Development Program. This permission for release of information is in effect from the date of signing this form and during the period of time my child is enrolled in NCOHSCDP and is pursuant to HIPAA and California law and includes, but is not limited to, any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or any other covered health care provider. I understand this written consent is voluntary and subject to revocation at any time.

_____ (Signature of Parent/Guardian)

_____ Date



Child's Name: _____

Date of Birth: _____

Instructions: Please answer the questions by circling "yes" or "no" or by writing in the requested information. To expediate the enrollment process if you answer yes to any of the questions, follow up will be required by the Health Specialist and/or the Nutrition Coordinator. In some cases **paperwork from the doctor will be required before the child can attend school.** All information is confidential. If you have any question, please call (707) 462-2582 or (800) 326-3122

NUTRITION CONDITIONS		
Are there any foods your child can not eat for medical reasons? If yes, please explain	YES	NO
Does your child have any FOOD allergies? If yes, please explain	YES	NO
Is there any food(s) your child should not eat for religious or personal reasons? If yes, please explain	YES	NO

HEALTH CONDITIONS		
Does your child have any allergic reactions to any of the following? <input type="checkbox"/> Medications or shots <input type="checkbox"/> Animals/Insects <input type="checkbox"/> Other If "yes", to any of the above, please explain:	YES	NO
Has your child recently been hospitalized or operated on? If "yes" when, and please explain:	YES	NO
Has your child recently had any serious accidents or illnesses? If "yes" please explain:	YES	NO
Has your child ever had a convulsion or a seizure? If "yes" when was the last seizure and what caused it?	YES	NO
Does your child have any bone or muscle problems? Does your child have any trouble sitting, crawling, pulling up or walking? If "yes" please describe:	YES	NO
Does your child need any special devices or adaptive equipment, or require any changes to the environment for health, safety or comfort? If "yes" please describe:	YES	NO
Has your child been diagnosed with asthma? If "yes" please answer the following questions:	YES	NO
Is your child currently taking medications for asthma?	YES	NO
Will your child need his/her asthma medication at school?	YES	NO
Does your child use a nebulizer?	YES	NO
What medications is your child taking for asthma and how often? _____ Who is the doctor you are working with to control your child's asthma? _____		
Is your child taking any prescription or over the counter medication regularly? If "yes" what is the medication and why is it being taken?	YES	NO
Has your child been diagnosed with any of the following? <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Heart/Blood Problems <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Kidney Problems	YES	NO

 Name and Signature of Parent/Guardian

 Date

NOTE: If Health/Nutrition questionnaire was completed 6 months before child was selected for enrollment, parents must review and update the information before child can be enroll. The questionnaire can also be updated and/or reviewed over the phone with parent by staff.

 Name and Signature of Parent/Guardian reviewing/updating questionnaire




































 Date reviewed/updated

 Name and Signature of staff reviewing/updating questionnaire

 Date reviewed/updated

HEAD START NUTRITION ASSESSMENT

CHILD'S FULL NAME: (FIRST AND LAST)	DATE OF BIRTH:	DATE:
SITE:	CLASSROOM:	
Is your child currently enrolled in the WIC program? YES NO	Are you receiving CalFresh (food stamps)? YES NO	
How is your child's appetite? (circle one) Excellent Good Fair Poor		
How many times a day does he/she eat, including snacks? _____	How often does he/she drink soda? _____ a week	
How many times a day does your child drink milk? _____	What type of milk? (Whole, 2%, 1%, etc.) _____	
What are your child's favorite foods?	Favorite fruits and vegetables?	
What foods does he/she dislike?		
Has a doctor ever told you your child is anemic? YES NO If so, when? _____ Name of Dr./Clinic: _____		
Is she/he currently taking iron supplements? YES NO		
Does your child have frequent diarrhea? YES NO	Does your child have frequent constipation? YES NO	
Do you have any concerns/comments about your child's eating habits or nutritional status? YES NO If yes, please explain:		

	Circle the foods your child eats and check the box that applies to how often they eat from each group: (Please check one box per row)	1-3 times a day	2-3 times a week	Once a week	Rarely
Dairy	Milk (any kind)  Cheese  Yogurt  <small>(except cream or cottage cheese)</small>				
Protein	      Meat & Poultry (any kind) Fish Eggs Beans(not green) Cottage Cheese Peanut Butter				
Grains	      Cereal (any kind) Bread (any kind) Rice Noodles, Spaghetti Crackers Tortillas				
Vitamin C foods	     Orange (or orange juice) Tomato (or tomato juice) Grapefruit (or juice) Broccoli Cabbage				
Vitamin A foods	Dark Leafy greens  Carrots  Apricots  Yams or Sweet Potatoes  Cantaloupe  Squash  <small>(spinach, romaine lettuce, mustard green, etc)</small>				
Sweets / Snacks	         Candy Chips Donuts, Cakes, Pies & Cookies Popsicles Punch, Hi-C, Kool-Aid Sugary Cereals				

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

NOTE: If Health/Nutrition questionnaire was completed 6 months before child was selected for enrollment, parents must review and update the information before child can be enroll. The questionnaire can also be updated and/or reviewed over the phone with parent by staff.

 Name and Signature of Parent/Guardian reviewing/updating questionnaire

 Date reviewed/updated

 Name and Signature of staff reviewing/updating questionnaire

 Date reviewed/updated



YOUR FAMILY & HEAD START FREQUENTLY ASKED QUESTIONS

What is Head Start?

Head Start is a federally funded program that began serving preschoolers from low income families in 1965. What sets Head Start apart from other programs is that, in addition to offering high quality early educational experiences, Head Start also provides children and families with a wide range of medical, dental, nutritional, mental health, special needs, and parent education services and referrals, absolutely free of charge to the family.

Over recent years, Head Start expanded by adding services for pregnant mothers, infants, and toddlers, through the Early Head Start program. Head Start and Early Head Start now serve children ages 0-5 years old.

Head Start welcomes and actively recruits children with special needs and does not discriminate against anyone on the basis of gender, sexual orientation, ethnic group identification, race, ancestry, national origin, religion, color, immigration status, mental or physical ability.

What does HSCDP believe?

The Head Start Child Development Program's (HSCDP) goal is to empower children to reach their highest potential. To do this, we work closely with you, the parent, because you are the most important teacher for your child. Parents are seen as partners in their child's education, and you will have the opportunity to become involved in the classroom, parent meetings, or through the Program Policy Council, which, as a group, makes policy decisions for the program.

Making learning fun is important and we will provide your child with activities that help them grow intellectually, socially, emotionally, and physically.

How does HSCDP work?

North Coast Opportunities HSCDP serves 341 children in Lake and Mendocino Counties. Preschoolers in the Head Start (HS) centers can attend school 4 days a week, 4 hours daily or 5 days a week, 6 hours daily. Our Peach center has one class that provides extended hours, 5 days a week, for working families.

Children under 3 years old may attend Early Head Start (EHS) centers, which combine state childcare funding to offer services for families with a need for full day care. (Note: Depending on income, parents may be required to pay a share of cost for the state childcare funded portion of the day). Pregnant mothers and children could also be enrolled in a home based option, which offers weekly visits from a Home Base Educator (HBE), and monthly socials with other home based families.

At both HS and EHS, the teacher visits the home at least twice a year and family services staff are always available to assist the family with community resources and referrals.

Why do we ask so many questions on the application & why is there so much paperwork?

Head Start services are provided free of charge to families and our program is held accountable for the federal and state funding we receive. There are many regulations and requirements that we must meet. Also, because we provide referrals and services for the whole family as well as the child, the more information you can provide us, the better we will be able to serve you. All information given to us is kept completely confidential and will not be shared without your written permission.

More questions? Give us a call. In Ukiah: 462-2582. Outside Ukiah: 1-800-326-3122

HEAD START WILL BENEFIT YOU AND YOUR CHILD, SO PLEASE APPLY TODAY!

Important Information



NCO Head Start Child Development Program will not discriminate against anyone. This means HSCDP will help all who qualify, and will not deny anyone based on age, race, color, national origin, sex, sexual orientation, religion, political beliefs, disability, or **immigration status**.

*NCO Head Start Child Development Program no discriminará a ninguna persona. Esto significa que HSCDP ayudará a todos los que califiquen, y no negará a nadie basado en edad, raza, color, origen nacional, sexo, orientación sexual, religión, creencia política, incapacidad, o **estatus migratorio**.*

NCO Head Start Child Development Program will not share any information about you with the Immigration and Naturalization Service (INS).

NCO Head Start Child Development Program no compartirá ninguna información sobre usted con el Servicio de Inmigración y Naturalización (INS).

All information you give us is used only to determine eligibility and need for your family.

Toda la información que usted nos da se utiliza para determinar solamente la elegibilidad y necesidad de su familia.