□Head Start

**OFFICE FSCR**

**LEUSD School District**

□Early HS

**Children and Family Services Preschool Programs – 565 Chaney Street, Building E, Lake Elsinore**

# Phone Interview/Documentation Checklist 2018-2019

| ☑ if present | |
|---|---|
| | Sites: JEC FD ___ MES FD___ LVS PT___ RRC PT ___<br>Willing to Travel? _____ Yes _____ No<br>You **MUST call for an appointment** to bring in documents<br>**(951) 235-7091** M-F 8:00 AM to 4:00 PM |
| **Special Needs Documentation (if any)** | |
| | IEP (Individualized Education Plan) or IFSP: If applicable |
| | Set-4-School/SNAP Referral |
| **Proof of Family Size** | |
| | Parents/Legal Guardians Picture Identification |
| | Birth Certificate *(Must bring original)* |
| | Foster Placement, Caregiver affidavit *(if applicable)* |
| **Proof of Residency** | |
| | Current utility bill or rental or lease agreement. Taxes, Driver's License, Gas, electric, or water bill must be dated within the last 30 days. (Must bring original) ***Handwritten addresses are NOT acceptable.*** |
| **Proof of Income Eligibility** | |
| | Check stubs for the last 30 days Wages/salary before deductions |
| | Federal Tax Return 2017 (1040,W2s, 1099s, etc) |
| | Social Security Benefits/Disability, Supplemental Security Income (SSI), Social Security Payment (SSA) *as long as it not received for a child*, Foster Agreement, Homeless/Mc Vento or TANF/Cal Works (Gen 2000/Passport to services) |
| | Child Support (if only received for participant)/Alimony |
| | Unemployment Compensation, Workers Compensation, Disability Income, Retirement pay/ Pension |
| | Other: |
| **Medical Documentation** | |
| | Immunization Record: Updated for preschool attendance |
| | TB Test documentation (date given, date read and signature) |
| | Physical: must be dated within the last 12 months before the first day of school. |
| | Medical Condition Documents: If applicable for allergies, cardiac, asthma, etc…***(If yes, Health Plan will be needed)*** |
| | Hemoglobin and Blood Lead readings |
| | Dental Exam Record |
| **Legal Documentation** | |
| | Child Custody Court documentation with official date stamp or pending case documents |
| | Release of information: Father, mother, guardian, or caregiver |

**FOR OFFICE USE ONLY**

Your child is:

□**NEW** □**Waitlisted**

These items are necessary to be on the Wait list:

1._____

2._____

3._____

4. _____

5. _____

□ At this time your child is not eligible for HS due to the income guidelines.
A guide of Community Preschool Programs was given by:
_____ (SSC initials).

SSC Notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**Child's Name** _____ **DOB:** _____ **Application#** _____ **2018 - 2019**

RIVERSIDE COUNTY OFFICE OF EDUCATION

Division of Early Learning Services
Head Start/Early Head Start Programs

# Head Start/Early Head Start Application

**Please Print Legibly Using Black Or Blue Ink Only**

| Office Use Only |
|---|
| CPID No.:_____ |
| Term:_____ |
| Site:_____ |

## Applicant (Child or Pregnant Woman) Information

| First Name: | Last Name: | Middle: | Gender: ❑ Male ❑ Female | Birth Date: / / |
|---|---|---|---|---|

Which program are you applying for? ❑ Early Head Start (EHS) ❑ EHS Pregnant Women ❑ Head Start

Which program option are you applying for? ❑ Full Day* ❑ AM Session ❑ PM Session ❑ Home-Based ❑ No Preference
**Note: To be prioritized for full day, both parents/guardians must be working (25+ hrs/wk) or in school full time (7+ units)*

| | |
|---|---|
| Does the applicant have a current IEP or IFSP? ❑ Yes ❑ No | If yes, can you provide a current copy of the IEP or IFSP? ❑ Yes ❑ No |
| Is the applicant currently in 24-hour foster care? ❑ Yes ❑ No | If yes, do you have Education Rights? ❑ Yes ❑ No |

Does applicant have special health needs, medical conditions, or allergies? ❑ Yes ❑ No If YES, please explain:

## Family Information

| | | | |
|---|---|---|---|
| Primary Guardian Name: | Birth Date: / / | Cell Phone: | E-mail Address: |
| Secondary Guardian Name: | Birth Date: / / | Cell Phone: | E-mail Address: |

| | | | |
|---|---|---|---|
| Primary Phone: | Home Phone: | Alternate Phone: | Alternate Phone: |

| | | |
|---|---|---|
| Do you authorize the program to send you important program information and notices through either of the following: | Text Message: ❑ Yes ❑ No | E-mail: ❑ Yes ❑ No |

| | |
|---|---|
| Living Address: | City/Zip: |
| Mailing Address *(if different from Living Address)*: | City/Zip: |

Has applicant experienced recent loss of housing? ❑ Yes ❑ No If YES, please describe current living arrangement:

| | |
|---|---|
| Parent(s)/Guardian(s) in the Home: ❑ One Parent ❑ Two Parents | Name of Person(s) Having Legal Custody of the Child: |
| Primary Language Spoken at Home: ❑ English ❑ Spanish ❑ Other:_____ | Preferred Language of Written Material: ❑ English ❑ Spanish ❑ Other:_____ |
| Do you have an open CPS case? ❑ Yes ❑ No | Do grandparents have guardianship of the applicant? ❑ Yes ❑ No |
| Family member at home with a permanent disability? ❑ Yes ❑ No | Incarcerated or terminally ill parent(s)? ❑ Yes ❑ No |

## List all other family members living in the household for whom you provide financial support NOT LISTED ABOVE

| First Name: | Last Name: | Birth Date: | Is this person related to the child's parent'(s)? | Is this person supported by the parent'(s) income? |
|---|---|---|---|---|
| | | / / | ❑ Yes ❑ No | ❑ Yes ❑ No |
| | | / / | ❑ Yes ❑ No | ❑ Yes ❑ No |
| | | / / | ❑ Yes ❑ No | ❑ Yes ❑ No |
| | | / / | ❑ Yes ❑ No | ❑ Yes ❑ No |
| | | / / | ❑ Yes ❑ No | ❑ Yes ❑ No |
| | | / / | ❑ Yes ❑ No | ❑ Yes ❑ No |
| | | / / | ❑ Yes ❑ No | ❑ Yes ❑ No |

Total* number of people living in the household (including you) for whom you provide financial support:
** Use box to the right to write the total number*

**AN INCOMPLETE APPLICATION WILL DELAY ENROLLMENT**

Applicant's Name: _____ Birth Date: _____

## Primary Guardian

Name: | Lives with Applicant: ❑ Yes ❑ No

Relationship to Applicant: | Has Legal Custody of Applicant? ❑ Yes ❑ No

Marital Status:
❑ Married ❑ Divorced ❑ Separated ❑ Single ❑ Widowed

**Income Sources** | Has Income: ❑ Yes ❑ No

Do you receive (Check all that apply): Monthly Amount

❑ CalWORKs "Cash Aid" $ _____
❑ Supplemental Security Income (SSI) $ _____
❑ Alimony/Child Support $ _____
❑ Other $ _____

**Employment Status**

❑ Employed ❑ Unemployed ❑ Seasonally Employed
❑ Retired ❑ Seeking Employment ❑ Disabled

Disabled from _____ To _____

**Employment Information**

Employer Name: | Employer Phone:

Pay Period: ❑ Weekly ❑ Every 2 Weeks ❑ Twice Per Month
❑ Monthly ❑ Other: _____

Gross Income: Total $_____ Per _____

Paid by: ❑ Cash ❑ Personal Check ❑ Company Check

Total Hours Worked per Week: _____

Do you authorize the program to contact your employer for verification? ❑ Yes ❑ No

**School or Training Information**

Are you in school or vocational/job training? ❑ Yes ❑ No

School Name: | School Phone:

Total School Units/Training Hours Per Week: _____

Are you an employee of RCOE Head Start? ❑ Yes ❑ No
Are you related to an RCOE Head Start employee? ❑ Yes ❑ No

## Secondary Guardian

Name: | Lives with Applicant: ❑ Yes ❑ No

Relationship to Applicant: | Has Legal Custody of Applicant? ❑ Yes ❑ No

Marital Status:
❑ Married ❑ Divorced ❑ Separated ❑ Single ❑ Widowed

**Income Sources** | Has Income: ❑ Yes ❑ No

Do you receive (Check all that apply): Monthly Amount

❑ CalWORKs "Cash Aid" $ _____
❑ Supplemental Security Income (SSI) $ _____
❑ Alimony/Child Support $ _____
❑ Other $ _____

**Employment Status**

❑ Employed ❑ Unemployed ❑ Seasonally Employed
❑ Retired ❑ Seeking Employment ❑ Disabled

Disabled from _____ To _____

**Employment Information**

Employer Name: | Employer Phone:

Pay Period: ❑ Weekly ❑ Every 2 Weeks ❑ Twice Per Month
❑ Monthly ❑ Other: _____

Gross Income: Total $_____ Per _____

Paid by: ❑ Cash ❑ Personal Check ❑ Company Check

Total Hours Worked per Week: _____

Do you authorize the program to contact your employer for verification? ❑ Yes ❑ No

**School or Training Information**

Are you in school or vocational/job training? ❑ Yes ❑ No

School Name: | School Phone:

Total School Units/Training Hours Per Week: _____

Are you an employee of RCOE Head Start? ❑ Yes ❑ No
Are you related to an RCOE Head Start employee? ❑ Yes ❑ No

I certify that the information in this application is true and complete to the best of my knowledge. I understand that failure to report correct information may be grounds for rejection of this application or termination of childcare services. I will notify the agency immediately if there is any change in my income, family size, home address, employment, or reason for needing childcare services.

Parent/Guardian Signature: _____ Date: _____

**CHILDREN AND FAMILY SERVICES**

**Early Childhood Education**

545 Chaney Street, Building E, Lake Elsinore, CA 92530
Office: (951) 253-7091 Fax: (951) 253-7185

# Release of Information

I give my permission for LEUSD Children and Family Services Preschool Programs to verify any information utilized to determine my families eligibility during the enrollement process and at the time my child is enrolled in a LEUSD Preschool Program.

I authorize the sharing of information between agencies to verify my income, eligibility and need for child care and/or support services. Agencies that may be contacted include, but are not limited to the Department of Public Social Services, training sites/schools, social service agencies, referring physicians, emergency shelters, and employers.

I give my permission for Children and Family Service Preschool Programs to request from and/or provide to other public funded agencies any eligibility information needed to ensure proper use of State/Federal funds.

If during the time my child is enrolled you find any information to be inaccurate or fraudugelent, I understand my child will be terminated from LEUSD Children and Family Service Preshool Programs.

| | |
|---|---|
| Child's Name | Relationship to Child |

| | | |
|---|---|---|
| # 1 Signature – Primary Adult | Print Name – Primary Adult | Date |

| | |
|---|---|
| Child's Name | Relationship to Child |

| | | |
|---|---|---|
| #2 Signature – Secondary Adult | Print Name – Secondary Adult | Date |

RIVERSIDE COUNTY OFFICE OF EDUCATION

Division of Early Learning Services
Head Start/Early Head Start Programs

# Physical Examination

Child's Name: _____ Date of Physical Examination: _____

Date of Birth: _____

***Head Start requires a complete CHDP equivalent health examination for entrance into the program.***

| CHDP Periodicity visit for: | 1 Mos | 2 Mos | 4 Mos | 6 Mos | 9 Mos | 12 Mos | 15 Mos | 18 Mos | 24 Mos | 30 Mos | 3 Yrs | 4 Yrs | 5 Yrs |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

| TB Risk Factor Assessment: | Blood Lead Risk Factor Assessment: |
|---|---|
| ❑ Risk factors not present; TB skin test not required | ❑ Risk factors not present ❑ Risk factors present |

| | | | | | |
|---|---|---|---|---|---|
| Hematocrit /Hemoglobin<br>9 Month 2,3,4 Years | Date: | Results: | Anemia:<br>❑ Yes ❑ No | Iron Supplements:<br>❑ Yes ❑ No | |
| Blood Lead Test: 12 and 24 Month<br>If no record, perform | Date: | Results: | Blood Pressure: | Date: | Results:____ / ____ |
| Tuberculin Skin Test | Date Given: | Date Read: | Results:<br>☐ Negative<br>☐ Positive | Chest X-ray<br>Date: | Results:<br>☐ Negative<br>☐ Positive |

| | | | |
|---|---|---|---|
| Height: ( %) | Weight: ( %) | BMI: | Head Circumference: |
| Vision: Right – 20/_____ Left – 20/ _____ | | Strabismus: ❑ Pass ❑ Fail | Hearing: ❑ Pass ❑ Fail |

| Examination Results | Normal for age | Abnormal (Describe Findings) | Not Tested | Examination Results | Normal for age | Abnormal (Describe Findings) | Not Tested |
|---|---|---|---|---|---|---|---|
| Anticipatory Guidance | | | | Eyes/Vision Observation | | | |
| Posture, Gait | | | | Ears/Clinic Assessment | | | |
| Birth Defects | | | | Developmental Screening | | | |
| Ears/Nose/Throat | | | | Autism Spectrum Disorder Screening | | | |
| Seizures | | | | Developmental Surveillance | | | |
| Mouth/Teeth Dental/Nutrition | | | | Psychosocial/Behavior Assessment | | | |
| Heart/Lungs | | | | Communication Skills/Speech | | | |
| Asthma | | | | Cognitive Skills | | | |
| Abdomen (Hernia) | | | | Maternal Depression Screening | | | |

Is the child cleared to enter preschool? ❑ Yes ❑ No

List any allergies, chronic conditions or special accommodations: _____

_____

List medications required at school (include medication name and dosage): _____

_____

Provider (Please print): _____ Signature: _____

Practice/Clinic Name: _____ Phone Number: _____

Address: _____

RIVERSIDE COUNTY OFFICE OF EDUCATION

Division of Early Learning Services
Head Start/Early Head Start Programs

# Dental Screening Results/Examen dental y resultados

Child's Name/Nombre del niño: _____ Date of Birth/ Fec. Nac.: _____

## Screening/Examen

Priority Criteria/Criterio para determinar prioridad:

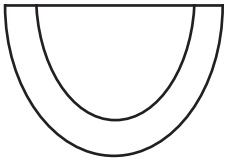
- ❑ Priority No.1 - immediate care
  Prioridad No.1 - Cuidado inmediato
- ❑ Priority No.2 - extensive amount of decay
  Prioridad No.2 - Demasiada caries
- ❑ Priority No.3 - obvious cavities
  Prioridad No.3 - Caries evidente
- ❑ Priority No.0 - No obvious cavities
  Prioridad No.0 - No hay caries evidente

Soft Tissue/Arch: ❑ Satisfactory/no follow-up necessary
Satisfactorio; seguimiento no necesario
❑ Further evaluation required/follow-up with dentist
Mayor evaluación necesaria; seguimiento con un dentista

Tejido blando/Arcada: ❑ Suspected area needing evaluation
Área de preocupación que necesita evaluarse

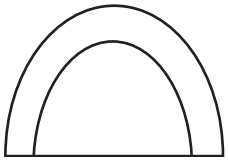
**(Mark tooth decay area)**
**(Indique la parte afectada con caries)**

Lower arch/Arcada mandibular

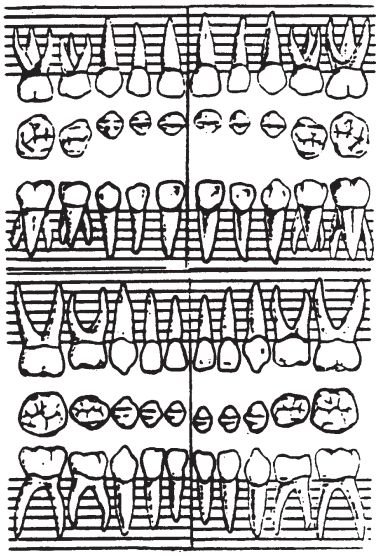


Palate/Paladar

Tongue/Lengua



Upper arch/Arcada maxilar



Lower dental arch: _____
Arcada dentaria inferior

Upper dental arch: _____
Arcada dentaria superior

Tongue: _____
Lengua

Palate: _____
Paladar

Lingual Frenulum: _____
Frenillo lingual

Upper lip: _____
Labio superior

Lower lip: _____
Labio inferior

Varnish Consent/: ❑ Yes ❑ No

Hygiene: ❑ Satisfactory/Satisfactorio ❑ Improve brushing by parent/Ayuda de los padres para mejorar el cepillado.
❑ Introduce flossing by parent/Ayuda de los padres para empezar el uso de hilo dental.

Dentist Signature/Firma del dentista: _____ Date/Fecha: _____

## Results/Resultados

❑ No follow-up needed at this time./No necesita seguimiento en este momento.

❑ Dental follow-up needed. Please make appointment with the dentist. Have dentist complete results portion of form and return to site./Necesita seguimiento. Por favor haga una cita con el dentista. Pida al dentista que llene la sección de resultados del formulario. Devuélva el formulario al plantel.

## Dental Follow-Up/Seguimiento dental

Treatment in process/En tratamiento: _____

Date of next appointment/Fecha de la próxima cita: _____

Treatment completed (date)/Tratamiento completo (fecha): _____

Dentist Signature/Firma del dentista: _____ Date/Fecha: _____

If you do not have dental insurance or dentist, please see site staff for a list of providers and assistance./Si no tiene seguro dental o dentista particular, por favor pida ayuda al personal del plantel y una lista de proveedores.