

Updated By:_

NAVAJO HEAD START CHECK LIST 2017-2018

Child's Name:		
	69	
Classroom:		
Birthdate:		

O Returning Student	O New Studen	Program:	HS or OEHS
Application Date (3 rd year significant change in income)	requires update or	O Child Plus I	≣ntry
		Child Plus	Indate
 Application Complete 		O Offina f 1do (opauto
Eligibility:	ied)	ie	
Type of Documents: O Check Stub	○TANF ○SSI ○	Statement (Verified)	OBirth Certificate / Announcement
Selection Criteria: Points			
Monitoring Signatures:			
Insurance: AHCCCS	OPrivate -	Туре	
-	_	_	
◯ Military – Type		None ON	ot Eligible
◯ CIB ◯ Map (Physica	I Address D	ower of Attorney	
OID Wap (Filysica	Address)	ower of Attorney	
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Health Requirements and Result	s:	Date	Due
1. Physical Exam / EPSDT (well-bab			
2. Blood Pressure			
3. HT/WT			
4. HCT/HGB			
5. Lead			
6. Allergies			
7. Dental			
8. Dental Screening			4
9. Fluoride			
10. Vision			
11. Stereopsis			74
12. Audio (Hearing)			
13. Developmental			
14. Social Emotional			
Notes:			
CA-ff Nower		Defe	
Staff Name:		Date:	

Date:



Navajo Head Start

Program Applied For		☐ Full Day ☐ Part Day	,
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Applicant & Family Member Informatic Region: □ □ □ □ □ □ □ □ □ □ □ Site:_____

Applica	nt									
First		Middle	Last	Suffix	Nicknam	e Birth	nday Gend	er Ce	nsus Numb	oer / Tribe
Race				Hispanic	English Profic	ciency	Other Language		Other La	anguage Proficiency
□ Asian	☐ Americ	an Indian/A	laska Native	□ Ýes	☐ Little	•	0 0		□ Little	,
☐ Black	□ Hawaii	an/Pacific Is	slander	□ No	☐ Moderate				□ Mode	rate
□ White	☐ Multi-R	Racial			□ None				□ None	
☐ Other: _					□ Proficient				□ Profic	ient
Primary H	lealth Cove	rage O	ther Coverage	Insurance #	Medicai	d Eligibility	Medica	aid #	Doo	ctor/Medical Home
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					□ On M					
					☐ Poter	ntially	5			
Denta	al Coverage	9	Dental Co	overage #			Dentist/De	ntal Home		
Primary	Adult									
First		Middle	Last	Suffix	Nickname	e Birth	ndav Gende	er Cer	nsus Numb	er / Tribe
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Race				Hispanic	English Profic	sionov	Other Language		Other La	nguage Proficiency
□ Asian	□ Amorio	an Indian/A	laska Native	□ Yes	☐ Little	lency	Offier Language		□ Little	riguage Proficiency
☐ Black		an/Pacific Is		□ No	☐ Moderate				□ Moder	ato
□ White	□ Multi-R		nariaci	L 140	□ None				□ None	aic
☐ Other:	_ man r	laciai			☐ Proficient				☐ Profici	ent
Highest Gra	ade Compl	eted		Employment Statu		Child's Re	ationship	Custody		ck all that apply:
☐ Associat		Grade 1	0				•	☐ Yes		1 1 1
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_ 0		☐ Master's				_ 00.			11 1001	□ Yes □ No
Email Add	ress:									
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First Race ☐ Asian	□ Americ	Middle an Indian/A	Last laska Native	Hispanic □ Yes	English Profic		•	er Cer	Other La	nguage Proficiency
First Race □ Asian □ Black	□ Americ	Middle can Indian/A an/Pacific Is	Last laska Native	Hispanic	English Profice □ Little □ Moderate		•	er Cer	Other La	nguage Proficiency
Race Asian Black White	□ Americ	Middle can Indian/A an/Pacific Is	Last laska Native	Hispanic □ Yes	English Profic		•	er Cer	Other La	nguage Proficiency
Race Asian Black White Other:	□ Americ □ Hawaii □ Multi-R	Middle an Indian/A an/Pacific Is Racial	Last laska Native	Hispanic □ Yes □ No	English Profice Little Moderate None Proficient	siency	Other Language		Other La	nguage Proficiency ate ent
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Additional Child (Non Applicant)

	This Section for Agency Use Only:	
Applicant Name: _	Birthday	

Addition	nal Child (Non-Applic	ant) *						
First	Middle	Last		Suffix	Nickname	Birthday	Gender	Census Number
Race Asian Black White Other:	☐ American Indian/Alaska ☐ Hawaiian/Pacific Islande ☐ Multi-Racial		Hispanic ☐ Yes ☐ No	English Pro Little Moderat None Proficier	e	Other Language	Other La Little Moder None Profici	
Addition	nal Child (Non-Applic	ant) *						
First	Middle	Last		Suffix	Nickname	Birthday	Gender	Census Number
Race Asian Black White Other:	☐ American Indian/Alaska ☐ Hawaiian/Pacific Islande ☐ Multi-Racial	r	Hispanic □ Yes □ No	English Pro Little Moderat None Proficier	e	Other Language	Other La Little Moder None Profici	
Addition	nal Child (Non-Applic	ant) *						
First	Middle	Last		Suffix	Nickname	Birthday	Gender	Census Number
Race Asian Black White Other:	☐ American Indian/Alaska ☐ Hawaiian/Pacific Islande ☐ Multi-Racial	r	Hispanic □ Yes □ No	English Pro Little Moderat None Proficier	e	Other Language	Other La Little Moder None Profici	
	nal Child (Non-Applic							
First	Middle	Last		Suffix	Nickname	Birthday	Gender	Census Number
Race Asian Black White Other:	☐ American Indian/Alaska ☐ Hawaiian/Pacific Islande ☐ Multi-Racial		Hispanic □ Yes □ No	English Pro	e	Other Language	Other La	
Addition	nal Child (Non-Applic	ant) *						
First	Middle	Last		Suffix	Nickname	Birthday	Gender	Census Number
Race Asian Black White Other:	☐ American Indian/Alaska ☐ Hawaiian/Pacific Islande ☐ Multi-Racial	r	Hispanic □ Yes □ No	English Pro Little Moderat None Proficier	e	Other Language	Other La Little Moder None Profici	
	nal Child (Non-Applic			2.41				
First	Middle	Last		Suffix	Nickname	Birthday	Gender	Census Number
Race Asian Black White Other:	☐ American Indian/Alaska ☐ Hawaiian/Pacific Islande ☐ Multi-Racial	r	Hispanic □ Yes □ No	English Pro Little Moderat None Proficier	re	Other Language	Other La Little Moder None Profici	
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First	Middle	Last		Suffix	Nickname	Birthday	Gender	Census Number
Race Asian Black White Other:	☐ American Indian/Alaska ☐ Hawaiian/Pacific Islande ☐ Multi-Racial		Hispanic □ Yes □ No	English Pro Little Moderat None Proficier	e	Other Language	Other La Little Moder None Profici	
	nal Child (Non-Applic	ant) *						
First	Middle	Last		Suffix	Nickname	Birthday	Gender	Census Number
Race Asian Black White Other:	☐ American Indian/Alaska ☐ Hawaiian/Pacific Islande ☐ Multi-Racial		Hispanic □ Yes □ No	English Pro	re	Other Language	Other La Little Moder None	

Page Two (2) Family Information, Income & Contacts

This Section for Agency Use Only:						
Applicant Name:	Birthday					

rai	mily Informa	ation													
Fan	nily Living Add	ress													
Sta	rted Living At Da	ate L	_iving Addre	ess		Addre	ess Line 2	ZIP	City			State	Cour	nty	
Fan	nily Mailing Add	dress							'						
San	ne as living?	Started	Using Date	Mailing	Address			Address Line 2	ZIP		City				State
ΠY	'es □ No														
Pho	one Number(s)			Type (c	check one)			Note (extension	or best t	me to call)		Opt In f	or Text N	∕lessa	ages
				□ Cell	☐ Home	□ Work	□ Other					☐ Yes	□ No		
				□ Cell	☐ Home	□ Work	□ Other					□ Yes	□ No		
				□ Cell	□ Home	□ Work	□ Other					☐ Yes	□ No		
F	Parental Status (check one)		Primary L		Home Fam		Active Dut Military	ty Referred by Welfare A		Receivii SNAP		WIC	(if	WIC appli	: ID icable)
	One				ПΥ	es	☐ Yes	□ Ye	es	□ Yes		□ Yes		.,	,
	Two				1 🗆	NO	□ No		10	□ No		□ No			
Fa	mily Income	9													
	ome Verified by						Verifi	cation Date		TANF S	tatus			SS	31
									☐ Yes	nerly on TA	□ No NF/No	t now	☐ Yes		
	Family	Α	mount	Per (for	example:	Annua	al Amount	Description (for				for examp			Note
	Member			week, mo	onth, year)			SSI, Job, Child	Support)	И	/2, che	ck stub)			
		\$				\$									
		\$				\$									
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Inco	ome Notes														
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	Name					Relat	tionship			Emergeno	cy Con	tact		lease	
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t	Physical Addre	ess					ZIP			City					State
Contact															
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			☐ Cell [☐ Home ☐ \	Work			☐ Cell ☐ Home	□ Work						ne 🗆 Work
	Name					Relation	ship			Emergen	-			ease	
7										☐ Yes		No	□ Ye	S	□ No
ţ	Physical Addre	ess					ZIP			City					State
Contact															
ပိ	Phone Numbe	r 1			Pho	one Num	ber 2			Phone Nu	ımber :	3			
			☐ Cell ☐	☐ Home ☐ \	Nork			☐ Cell ☐ Home	□ Work				□ Cell □] Hom	ne 🗆 Work
	Name					Relation	ship			Emergen	cy Con	tact	Rel	ease	То
m										□ Yes		No	□Ye	es.	□ No
	Physical Addre	ess					ZIP			City				St	tate
Contact															
Ö	Phone Numbe	r 1			Pho	one Num	ber 2			Phone Nu	ımber :	3			
			□ Cell □	☐ Home ☐ \				□ Cell □ Home	□ Work				□ Cell □	1 Horr	ne 🗆 Work

Page Three (3)

	This Section for Agency Use Only:
Applicant Name:	Birthday

Applicant Eligibility & Enrollment Information

Eligibility									
Program Term	Agency		Initial State	us		Status Date			
2017-2018'			□ New	☐ Accepted	☐ Waitlisted	I			
Releases Signed	Date Signed		Child will t	ransition to					
□ Yes □ No									
Location Preference Priority	Site			Classroom		Funding			
1st									
2nd									
3rd									
Enrollment Notes									
Application Date	Application Status				Application	on Number Participation Year			
	☐ Complete & Verified ☐ Incomplete		olete, info no specify in n						
Eligibility Date	Number in Family	El	igibility Incor	me					
CACFP Date	CACFP Income	Pe	er (for examp	ole, year, month,	other)	CACFP Status			
				(□ Pai □ Red	e (full reimbursement) d (minimum reimbursement) duced price (reduced reimbursement) ent Information Technology USA, Inc. 10/26/2016			
Agency Specific									
Notes:									
On a Separate Piece of Paper <u>Draw A Map From The Nearest Head Start Center To Your Home</u> . In addition, please complete the Transportation Request Survey Form to complete you application.									
Certification: I certify that terminated and I may be su confidence within the agen	ıbject to legal action. Ta	lso under	stand that	the information	_	cy's programs may be lication will be held in strict			
Parent/Guardian Signature)				Date				
Completing Staff Member					Date_				

Navajo Head Start



P.O. Box 3479 Window Rock, AZ 86515 928-871-6902 (Phone), 928-871-7866 (Fax)

ELIGIBILITY SELECTION CRITERIA

Applica	ant Name	(First,	MI,	Last)
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INSTRUCTIONS: Check each box that applies based on information from the application and/or other sources. Write comments as needed. Type of insurance can only check one. Symbol (^) third party verification (Family, Friends, Local CHR / Chapter, etc.). Symbol (*) requires verification of documents to be attached to receive points. Upon completion Sign form below.

PARENTAL STATUS		AGENCY CONSIDERATION		
Foster Parent	40	Navajo Native American	40	
Non Parent/Guardian	20	Other Native American	30	
One Parent	10	Participant <u>DOES NOT</u> have any type of Medicaid or Health Insurance (Immediate referral)		
Two Parent	0			
INCOME		Participant's Mother is Teen Parent (13-19)	30	
Below 100% of Poverty Guidelines	40	Participant is referred by Professional (i.e. Social Services, MD, LEA, WIC, Shelter, Early Intervention, etc)		
100-130% of Poverty Guidelines	20			
Over 130% of Poverty Guidelines	0			
HEAD START (Child's Age as of Sept 1)		(ATTACHED Document)		
4 Yrs 6 Mon or older	40	Participant has parent/guardian Active Military Duty or Military Deployment		
4 Yrs 0 Mon to 4 Yrs 5 Mon	20			
3 Yrs 6 Mon to 3 Yrs 11 Mon	10	Participant's parent/guardian is Military Veteran	20	
3 Yrs 0 Mon to 3 Yrs 5 Mon	5	Participant receives Medicaid/AHCCCS/CHIP	20	
2.11 Yrs and Below	0	Parent is Unemployed or Part-Time Employed	20	
EARLY HEAD START		Participant has sibling already in Head Start	20	
Neonatal - 6 Months	40	Participant suffers chronic health problems	20	
7 - 12 Months	30	Participant has Prenatal Mother/Guardian	20	
13 - 18 Months	20	Housing - No Electricity and/or No Indoor Plumbing	^ 20	
19 - 24 Months	10	Participant only has Private Insurance and/or does		
25 - 30 Months	5	not qualify for Medicaid.		
31 - 35 Months	0	Family member is mentally ill (i.e. depression,		
REQUIRED CONSIDERATION		anxiety, schizophrenia)	10	
Diagnosed Disability - IEP/IFSP	* 300	There has been a death in the household within the		
Diagnosed Disability - Services provided by		past 6 months	10	
Professional	* 150	Participant previously enrolled in other Head Start	10	
Participant is transitioning from EHS	125	Participant has Incarcerated Parent or on Probation	10	
Family Receiving SSI	* 100	Parent is attending school/vocational training	10	
Family Receiving NNPSR (TANF)	* 100	Parent suffers chronic health problems/disability	10	
Homeless Family / Childrens Home	^ 100	Chronic means long term: (i.e. Diabetes, Cancer, High Blood Pressure, Sickle Cell Disease, Asthma, PTSD, etc.)		

Write Additional Notes here:

		TOTAL POINTS
Signature of Staff Completing Form / Date	Signature of Monitoring Staff Person / Date	

nild's Name:	Date:	
)		
ter information only into the shaded be	Income Calculation Worksheet exes. if they apply.	
eekly Pay	(Four pay checks per person must be entered if you use this box)	Consistent Support
		Payments (child support
Parent/Guardian 1		etc.)
) ÷ 4 =x 52 =	
•	Pay Check 3 Pay Check 4 Average Weekly Annua	
Parent/Guardian 2		
(+	+) ÷ 4 =x 52 =	
Pay Check 1 Pay Check 2	Pay Check 3 Pay Check 4 Average Weekly Annua	
-Weekly	(Two pay checks per person must be entered if you use this box)	
Parent/Guardian 1		
+) ÷ 2 =x 26 =	
Pay Check 1	Pay Check 2 Average Bi Weekly Annua	
Parent/Guardian 2		
•) ÷ 2 = x 26 =	
Pay Check 1	Pay Check 2 Average Bi Weekly Annua	
Tay Shook T	ray oncore 2 reading 5 reading	
ce a Month	(Two pay checks per person must be entered if you use this box)	_
ce a worth	(1 wo pay direcks per person must be entered if you use this box)	
- 1		-
Parent/Guardian 1		
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Pay Check 1	Pay Check 2 Average Bi Weekly Annua	
Parent/Guardian 2		***************************************
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nthly		
Parent/Guardian 1	Parent/Guardian 2	
+	x 12 =	
Pay Check	Pay Check Annua	Total
al of All Pay Sources From Above		Total Annual
	OR	
nual W-2	(If this box is used, you will not use the boxes above)	
++		
W2 W2	W2 W2 W2	Total Annual
	OR	es de la companya de

NOTE: PLACE TOTAL ANNUAL INCOME ON THE INCOME/ELIGIBILITY VERIFICATION FORM (#579).

STAPLE THIS FORM ALONG WITH COPIES OF INCOME DOCUMENTS TO THE 579.

Total Annual

Navajo Head Start Categorically Eligibility Verification Form

λLI	1. Child's Name:					
ELIGIBILITY	2. Child's date of birth: Age: (Year / Months)					
AGE EL	3. This child is eligible to participate in the program YES NO					
CATEGORICAL ELIGIBILITY	4. Check the appropriate category of eligbility for this child and documentation used:					
CAT	Homeless Foster Care					
	5. Parent / Guardian Authorization Signature:Date:					
	Third Party Name:Title:					
	Contact Number:					
λL	6. Head Start Staff Verifying:Title:					
GIBII	Date verified:Time Verified: Circle One: Phone Interview/In Person					
	Notes:					
ALL						
VERIFYING CATEGORICALLY ELIGIBILITY	7. What documentation was used to determine categorically elgibility?					
САТЕ	Foster Care Reimbursement					
VING	Court Document; Legal or Government Issued Document					
ERIF	Describe:					
	Child Welfare Document attesting foster care					
	Other					
	Staff Singatures Required					
	Staff Signature: Date of eligbility verification:					
TIO	Staff Name: Title:					
CERTIFICATION	Monitoring Signature:					
CER	Monitoring Name:Title:					

Referencing OMB 0907-0374.

Referencing: 45 CFR 1305.4(a)(c), (d) and (e). To be eligible for Head Start services, a child must be at least three years old by the date used to determine eligibility for public school in the community in which the Head Start program is located, except in cases where the Head Start program's approved grant provides specific authority to serve younger children. (Head Start programs are required to verify family income before determining a child is eligible to participate in the program.

Navajo Head Start Income Eligibility Verification

ŁΙ	1. Child's Name:				
ELIGIBILITY	2. Child's date of birth: Age:	(Year / Months)			
AGE EL	3. This child is eligible to participate in the program	YES NO			
	* Determining Categorically Eligible utilize Categorically Elibility Verification form.				
EARNED INCOME ELIGIBILITY (UTILIZE FAMILY INCOME GUIDELINES)	Income Calculation: \$ Document used to determine income eligibility: Income Tax Form 1040 W -2 Self Reliance Documentation Pay Stub or Pay Envelopes Written Statement from employers SSI Documentation Unemployment Unemployed (does not work). Note: Requires third party verification. Complete Other	Income (check box 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 Al/AN programs Counted as part of the 49% maximum			
ITY (Third Party Verification:	for AI/AN programs			
GIBII	5. Parent / Guardian Authorization Signature:	Date			
NE EL	Third Party Name:				
NCON	Contact Number:				
NED I	6. Head Start Staff Verifying:				
EAR	Date verified:Time Verified:	Circle One: Phone Interview/In Person			
	Notes:				
	Notes.				
	Staff Signatures Required.				
NO		Date of eligbility verification:			
ICATION	Staff Signatures Required.	Date of eligbility verification: Title:			
CERTIFICATION	Staff Signatures Required. Staff Signature:				

Referencing OMB 0907-0374.

Referencing: 45 CFR 1305.4(a)(c), (d) and (e). To be eligible for Head Start services, a child must be at least three years old by the date used to determine eligibility for public school in the community in which the Head Start program is located, except in cases where the Head Start program's approved grant provides specific authority to serve younger children. (Head Start programs are required to verify family income before determining a child is eligible to participate in the program.