

Head Start

2390 W Hwy 56 #1
Cedar City, UT 84720
(435) 586-6070
Toll free 1-800-796-6070
Fax 1-435-586-5232



Dear Parent/Guardian,

Thank you for your interest in Southern Utah University Head Start, a FREE family-centered preschool program. Well-trained, dedicated staff members provide high quality education, health, family, and support services to low-income and/or at-risk Head Start families in southwestern Utah.

Eligibility for Head Start is based on Income, Family Size, Child Need and Family Needs. Children are eligible to attend Head Start the two years before they begin kindergarten. First priority is given to those who will be attending kindergarten the next year. Children and families are enrolled in the Head Start program at no financial cost, but parents are asked to contribute time and expertise.

- Your child must be either 4 (or 3) years old by September 1, 2009, to qualify for the 2009-2010 Program Year (which begins in August 2009). Children who will be 4 years old by September 1, 2009 are more likely to be enrolled.
- Most Head Start families must meet federal Poverty Guidelines for income and family size (see back page). A few slots are available for families making 130% of Federal Poverty guidelines. Ten percent of enrollment slots are reserved for children with special needs, regardless of income.

Please complete the enclosed application and submit it along with items listed on the checklist on page 2 to help us process your child's application.

If you have enrollment questions, please call the Head Start Office at 435-586-6070 then 0 (or 1-800-796-6070 then 0) and ask to speak to the Enrollment Coordinator.

We look forward to the possibility of serving your child and your family!

Virginia B. Higbee, Director

Esta aplicación está disponible en Español.
Llame por favor al 1-800-586-6070 para recibir una aplicación en Español.

Please complete the application and send copies of the following items:

✓ **Immunization Record**

4 HIB	4 DTaP	3 Polio	1 MMR	3 HEP B	2 HEP A	1 Varicella Or proof of chicken pox	Pneumococcal Or PCV-7
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✓ **Birth Certificate** (or other proof of birth): must include child's name, birth date, and parent's names.

✓ **Income verification** (one of the following): W2 form, paycheck stubs, letter from employer, or letter from TANF)

✓ **Insurance card** (If you have private insurance, Medicaid, CHIP, etc.)

✓ [If applicable] **Proof of Public Assistance** (SSI, DWFS, Child Care Assistance, Food stamps)

✓ [If applicable] **A referral letter and/or IEP** (Individualized Education Plan) if your child has special needs.

✓ [If applicable] **DWFS custody letter** for your child

PLEASE NOTE THAT IF ALL ITEMS LISTED ABOVE ARE NOT PROVIDED WITH YOUR APPLICATION, WE WILL BE UNABLE TO COMPLETE THE ENROLLMENT PROCESS. Please call the Enrollment Coordinators at 435-586-6070 then 0 if you have questions or need assistance in getting any of these records.

The following groups may receive preference in enrollment:

- Children who have disabilities or special needs.
- Children whose family participates in the TANF Program
- Children whose family meets the definition of 'homeless':

The federal government's legal definition of homelessness based on the McKinney-Vento Homeless Education Assistance Act is anyone who...

- Lacks a regular, fixed and adequate nighttime residence (sub standard housing).
- Is sharing housing due to economic struggles (double-up, including relatives).
- Is living in a shelter, hotel or motel.
- Is living in a public place not designed for sleeping (cars, parks).
- Is an unaccompanied youth.
- Is a child or youth awaiting foster care placement.
- Is a child or youth abandoned in a hospital.
- Is a migrant child who qualifies under any of the above

Bus transportation is provided in Delta and on a limited basis in St. George

FREQUENTLY ASKED QUESTIONS

1. How much does Head Start cost?

Head Start is a free program; there is no cost to parents for any services.

2. What kind of involvement is required for parents?

Parents/guardians should plan to volunteer in the classroom, help plan the curriculum to individualize for your child, and participate in monthly parent meetings. You may be elected to represent your class on the Policy Council and participate as Head Start leaders.

3. What if my child isn't yet toilet trained?

Children who attend SUU Head Start should possess the following skills:

- a. Be toilet trained
- b. Be able to use the toilet by themselves
- c. Be able to change clothes if they have a wetting accident
- d. Be able to wash their hands after toileting.

4. Once I complete and turn in my child's application what will happen next?

Upon receiving your application, Head Start Enrollment Specialists will review your application and notify you if more information is needed.

5. When will I hear if my child is in the program?

If you turn in an application between January and June 30 (for the next program year-starting in August), and IF your child is selected to attend SUU Head Start, you will receive a letter by July 15. Applications arriving after June 30 will be processed as quickly as possible.

After August, your child's name will be placed on a waiting list. During the school year, you will be called by a Head Start Enrollment Specialist if your child has been selected for enrollment.

6. What if I move after I submit my application?

It is important to notify SUU Head Start as soon as possible when there is a change in address and/or phone number. Please call us at 435-586-6070, or toll free 1-800-796-6070 Ext. 23 or 10 to update your new phone and address.










7. How is Head Start different from other preschools?

Head Start respects parents as the most important teacher, first and foremost. All activities involve the parent's input and knowledge of their children. Head Start also aims to help the family become stronger through services, knowledge, and participation.

8. Where do I find more information about SUU Head Start?

www.suu.edu/headstart or call 435-586-6070, ext. 23

2009 - 2010 Income Guidelines

Size of Family Unit	Yearly	Monthly	Weekly
 1	\$ 10,830.00	\$ 902.50	\$ 208.27
 2	\$ 14,570.00	\$ 1,214.17	\$ 280.19
 3	\$ 18,310.00	\$ 1,525.83	\$ 352.12
 4	\$ 22,050.00	\$ 1,837.50	\$ 424.04
 5	\$ 25,790.00	\$ 2,149.17	\$ 495.96
 6	\$ 29,530.00	\$ 2,460.83	\$ 567.88
 7	\$ 33,270.00	\$ 2,772.50	\$ 639.81
 8	\$ 37,010.00	\$ 3,084.17	\$ 711.73
 *Add \$3,740 for each family member over 8			





SUU PO Box 8985
 2390 W Hwy 56, Suite 1
 Cedar City, UT 84720
 Phone: (435) 586-6070 or
 1-800-796-6070 ext. 23

Complete one copy for **each** eligible child
 If you need help with paperwork, call 1-800-796-6070

CHILD DATA

1. Child's Name:

First Name _____ MI _____ Last Name #1 _____ Last Name #2 _____

2. Nickname:	3. Date of Birth: MM / DD / YY	4. SSN:	5. Gender: M F	6. Home Phone:
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7. Address: _____ **Effective Date:** _____
 Street City State Zip (MM / DD / YY)

8. Mailing Address (if different from above): _____ **Effective Date:** _____
 P.O. Box or Street City State Zip (MM / DD / YY)

9a. Was the child previously enrolled in Head Start / Early Head Start? YES NO	9b. If yes, how many years did he/she attend? 1 2 3
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10. Ethnicity (choose one): <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Non-Hispanic / Non-Latino	11. Race (choose only one): <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> Asian <input type="checkbox"/> White	<input type="checkbox"/> Black or African American <input type="checkbox"/> Unspecified	<input type="checkbox"/> Bi-racial / Multi-racial <input type="checkbox"/> Other: _____
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12. Language Spoken at Home: Primary: English Spanish Other: _____ Secondary: English Spanish Other: _____	13. How well does the child speak English? <input type="checkbox"/> Very Well <input type="checkbox"/> Not Well <input type="checkbox"/> Well <input type="checkbox"/> Not at all
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14a. Do you use or need full-year and/or full-day child care? YES NO	14b. Do you receive subsidized child care? YES NO
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14c. Primary source of child care when child is not in Head Start (choose only one):
 Family Child Care Home Child Care Center or Classroom Public School Pre-Kindergarten Program
 At Home or at Another Home with a Relative or Unrelated Adult Other: _____

INCOME DATA

16. Number of Adults:	17. Number of Children:	18. Number of adults contributing to income in home:
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19. MOTHER'S Income	20. FATHER'S Income	21. Parent Signature(s) I certify that this information is correct to the best of my knowledge and is subject to verification. X _____ Date Mother X _____ Date Father
Employment: \$	Employment: \$	
Military / VA:	Military / VA:	
Child Support:	Child Support:	
Other:	Other:	
Total Monthly Income:	Total Monthly Income:	
Total Yearly Income: \$	Total Yearly Income: \$	

STAFF USE ONLY

Eligibility Determination Statement I hereby do certify that the family is eligible to participate in the H.S. Program. I attest that I have examined the documents (checked) below and certify that the family is eligible in accordance with Head Start regulations and ERSEA policies.

Documents Reviewed (check all that apply)

<input type="checkbox"/> Individual Tax Form 1040	<input type="checkbox"/> Pay Stubs / Pay Envelopes	<input type="checkbox"/> Written Employer Statement	<input type="checkbox"/> Current TANF Receipts	<input type="checkbox"/> W-2 Form	<input type="checkbox"/> Unemployment
<input type="checkbox"/> Work History – Verification of Employment		<input type="checkbox"/> Written Verification or Verbal Declaration of Income		<input type="checkbox"/> Other	

Center:	Class:	Start Date:	Income Eligibility Date:	X _____ Staff's Eligibility Verification Signature Date
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MOTHER'S / MOTHER FIGURE'S DEMOGRAPHIC DATA

1. Mother's / Mother Figure's Name:

First Name _____ MI _____ Last Name #1 _____ Last Name #2 _____

2. Nickname:	3. Date of Birth: MM / DD / YY	4. SSN:	5. Gender: M F	6. Are you the legal guardian of this child? YES NO
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7. Home Phone:	8. Work Phone:	9. Cell Phone:
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10. Living & Mailing Address: _____ **Effective Date:** _____

Street _____ P.O. Box _____ City _____ State _____ Zip _____ (MM / DD / YY)

11. Ethnicity (choose one): <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Non-Hispanic / Non-Latino	12. Race (choose only one): <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Bi-racial / Multi-racial <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unspecified <input type="checkbox"/> Other: _____
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13. Language Spoken at Home: Primary: English Spanish Other: _____ Secondary: English Spanish Other: _____	14. How well does the mother speak English? <input type="checkbox"/> Very Well <input type="checkbox"/> Not Well <input type="checkbox"/> Well <input type="checkbox"/> Not at all	15. Marital Status: Divorced Married Separated Single Widowed
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16. Occupational Status (circle all that apply):

Start Date: _____ **End Date:** _____

Paying Job: Full-time (34+ hours weekly) Part-time Seasonal Employed and in School
Unemployed: Time since last job: _____ months No previous employment experience
Other: Homemaker Retired Unable to work due to disability Not applicable
In Job Training Program: With Salary Without Salary

17. Educational Status/History (circle all that apply):

Start Date: _____ **End Date:** _____

School Full-time Less than 6th grade
 High School Diploma/GED Less than High School/GED
 Trade/Business Qualification Associate's Degree
 Bachelor's Degree Other

18a. Was this parent under 17 at the birth of the FIRST child in family?
YES NO

18b. Was this parent over 41 at the birth of the LAST child in family?
YES NO

19a. Is applicant currently pregnant? YES NO **19b. If yes, due date:** _____

FATHER'S / FATHER FIGURE'S DEMOGRAPHIC DATA

1. Father's / Father Figure's Name:

First Name _____ MI _____ Last Name #1 _____ Last Name #2 _____

2. Nickname:	3. Date of Birth: MM / DD / YY	4. SSN:	5. Gender: M F	6. Are you the legal guardian of this child? YES NO
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7. Home Phone:	8. Work Phone:	9. Cell Phone:
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10. Living & Mailing Address: _____ **Effective Date:** _____

Street _____ P.O. Box _____ City _____ State _____ Zip _____ (MM / DD / YY)

11. Ethnicity (choose one): <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Non-Hispanic / Non-Latino	12. Race (choose only one): <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Bi-racial / Multi-racial <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unspecified <input type="checkbox"/> Other: _____
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13. Language Spoken at Home: Primary: English Spanish Other: _____ Secondary: English Spanish Other: _____	14. How well does the father speak English? <input type="checkbox"/> Very Well <input type="checkbox"/> Not Well <input type="checkbox"/> Well <input type="checkbox"/> Not at all	15. Marital Status: Divorced Married Separated Single Widowed
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16. Occupational Status (circle all that apply):

Start Date: _____ **End Date:** _____

Paying Job: Full-time (34+ hours weekly) Part-time Seasonal Employed and in School
Unemployed: Time since last job: _____ months No previous employment experience
Other: Homemaker Retired Unable to work due to disability Not applicable
In Job Training Program: With Salary Without Salary

17. Educational Status/History (circle all that apply):

Start Date: _____ **End Date:** _____

School Full-time Less than 6th grade
 High School Diploma/GED Less than High School/GED
 Trade/Business Qualification Associate's Degree
 Bachelor's Degree Other

18a. Was this parent under 17 at the birth of the FIRST child in family?
YES NO

18b. Was this parent over 41 at the birth of the LAST child in family?
YES NO

1. Child's Name:

First Name _____ MI _____ Last Name #1 _____ Last Name #2 _____

2. Type of Services or Financial Assistance Received (choose all that apply and enter start and end dates)

No Services Received

	Start Date	End Date		Start Date	End Date
Medicaid / CHIP.....	_____	_____	Unemployment Insurance	_____	_____
TANF.....	_____	_____	Public Housing Assistance	_____	_____
WIC.....	_____	_____	Energy Program Assistance	_____	_____
Supplemental Security Inc (SSI)	_____	_____	EPSDT.....	_____	_____
Foster Care / Adoption	_____	_____	Child Support / Alimony	_____	_____
			Other: _____	_____	_____

3. Family Type (choose only one)

- Two Parent Family
- Single Parent Family (mother figure only)
- Single Parent Family (father figure only)
- Foster Family
- Single Parent Family (mother figure only) Living with Partner
- Single Parent Family (father figure only) Living with Partner
- Other Relative(s)
- Other Family Type: _____

4. Type of Housing (choose only one)

- Apartment
- Community Shelter
- Homeless / No Housing
- Hotel / Motel Room
- House
- Migrant Housing
- Mobile Home / Trailer
- Other: _____

5. Housing Payment Arrangement (choose only one)

- Exchange Services for Housing
- Make No Payment for Housing
- Receive Subsidized Housing
- Own Housing
- Rent Housing
- Other: _____

6. Length of Time at Current Address:

- Less than 6 months 6 – 12 months 1 – 2 years 2+ years

7. Number of Moves in the Past 12 Months:

8a. Are you currently homeless?
(refer to definition in cover letter)

YES NO

8b. Length of Time Homeless:

- Less than 1 month 1 – 3 months 3 -6 months 6+ months

9a. Primary Means of Transportation:

- No Primary Means of Transportation
- Private Vehicle (car, truck, van)
- Friend/Relative's Vehicle
- Public Transportation
- City Bus
- Taxi
- Parent Transportation
- School Bus
- Other: _____

9b. Secondary Means of Transportation:

- No Secondary Means of Transportation
- Private Vehicle (car, truck, van)
- Friend/Relative's Vehicle
- Public Transportation
- City Bus
- Taxi
- Parent Transportation
- School Bus
- Other: _____

10. How did you hear about Head Start?

11. Comments:

12. Others Living at Home:

Total Number in Household: _____

Family Member #1	Age	Relationship to Child	Family Member #5	Age	Relationship to Child
_____	_____	_____	_____	_____	_____
Family Member #2	Age	Relationship to Child	Family Member #6	Age	Relationship to Child
_____	_____	_____	_____	_____	_____
Family Member #3	Age	Relationship to Child	Family Member #7	Age	Relationship to Child
_____	_____	_____	_____	_____	_____
Family Member #4	Age	Relationship to Child	Family Member #8	Age	Relationship to Child
_____	_____	_____	_____	_____	_____

1. Child's Name:

First Name

MI

Last Name #1

Last Name #2

2. If you do not currently have a doctor, dentist, or a way to pay for appointments would you like help? YES NO

3. Conditions Which May Be Important In An Emergency (choose all that apply):Allergies Bites: _____ Food: _____ Medication: _____ Other: _____Conditions Asthma Diabetes Seizure Other: _____

4. Is the condition(s) currently under control / care by physician? YES NO

5a. Do you have concerns about your child's overall health and development?

YES

NO

5b. Describe Concerns:**5c. Concerns Expressed By (choose one):** Medical Provider Primary Care Provider Family Member Program Staff Social Service Agency Other: _____**6. Mark Below All That Apply:**

<input checked="" type="checkbox"/>	Diagnosed Disabilities	Evaluated By:	Suspected	Identified	Date
	Health Impairment		YES NO	YES NO	
	Emotional / Behavioral Disorder		YES NO	YES NO	
	Speech or Language Impairment		YES NO	YES NO	
	Mental Retardation		YES NO	YES NO	
	Hearing Impairment, Including Deafness		YES NO	YES NO	
	Orthopedic Impairment		YES NO	YES NO	
	Visual Impairment, Including Blindness		YES NO	YES NO	
	Learning Disability		YES NO	YES NO	
	Autism		YES NO	YES NO	
	Traumatic Brain Injury		YES NO	YES NO	
	Non-categorical / Developmental Delay		YES NO	YES NO	
	Multiple Disabilities (including deaf-blind)		YES NO	YES NO	
	ADD and ADHD		YES NO	YES NO	
	Other: _____		YES NO	YES NO	

7. Does your child have an Individualized Education Plan (IEP)? YES NO

8. Is the child able to use the toilet by him/herself? YES NO

9. Are they able to change their own clothes if they have a wetting accident? YES NO

***** Please provide referral document(s) if the child has diagnosed disabilities (ex. IEP, Doctor Note, etc.) *****

If any of the following apply, please explain in more detail if desired.

Child's Name:

First Name

Last Name

1. Have there been negative changes in employment, living conditions, or income?

2. Is anyone living in the household with disabilities and / or health problems?

3. Is child in foster care or living with someone other than the parents?

4. Was child born with, or has health problem, allergies, disabilities, or special needs?

5. Briefly describe the family crisis so we may better prepare for the child (death, divorce, separation, job loss, recent move, substance abuse, incarceration, abuse, mental health, etc.) Use other side of paper if needed.
