



**Mandan, Hidatsa, Arikara Nation
Head Start**

509 9th Street North
New Town, ND 58763
(701) 627-4820 Fax (701) 627-4401

Enrollment Application 2023-2024



Completed Application requirements:

1. Application
2. Birth Record - Birth Certificate
3. Tribal Enrollment (Extra 50 pts.)
4. Income Documentation - Copy of pay stub/direct deposit, W-2, Employer statement.
5. Physicals & Required Blood work (HGB, A1C and Lead) before school starts.
(To be done no earlier than June 1st)
6. Up to date Immunizations

Returning students:

1. Application
2. Income Documentation (UPDATED REQUIRED)
3. Physicals & Required Blood work (HGB and A1C)- Physicals are required before returning to school. (To be done no earlier than June 1st)
4. Updated Immunizations

Head start is accepting the following information: Birth Certificate, Enrollment, Insurance cards and Income documents sent through e-mail. We would appreciate it if you are sending information to include your name as the guardian and the child's name. Documents can be e-mailed to wajones@mhanation.com.

(If printing or scanning documents please keep them to one sided only)

Applicant & Family Member Information

Applicant								
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Enrollment #
Race			Hispanic	English Proficiency	Other Language	Other Language Proficiency		
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native		<input type="checkbox"/> Yes	<input type="checkbox"/> Little		<input type="checkbox"/> Little		
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander		<input type="checkbox"/> No	<input type="checkbox"/> Moderate		<input type="checkbox"/> Moderate		
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial			<input type="checkbox"/> None		<input type="checkbox"/> None		
<input type="checkbox"/> Other: _____				<input type="checkbox"/> Proficient		<input type="checkbox"/> Proficient		
Primary Health Coverage		Other Coverage	Insurance #	Medicaid Eligibility	Medicaid #	Doctor/Medical Home		
				<input type="checkbox"/> Not Eligible				
				<input type="checkbox"/> On Medicaid				
				<input type="checkbox"/> Potentially				
Dental Coverage		Dental Coverage #		Dentist/Dental Home				

Primary Adult								
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Enrollment ID
Race			Hispanic	English Proficiency	Other Language	Other Language Proficiency		
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native		<input type="checkbox"/> Yes	<input type="checkbox"/> Little		<input type="checkbox"/> Little		
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander		<input type="checkbox"/> No	<input type="checkbox"/> Moderate		<input type="checkbox"/> Moderate		
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial			<input type="checkbox"/> None		<input type="checkbox"/> None		
<input type="checkbox"/> Other: _____				<input type="checkbox"/> Proficient		<input type="checkbox"/> Proficient		
Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:		
<input type="checkbox"/> Associate's	<input type="checkbox"/> Grade 10	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full Time & Training	<input type="checkbox"/> Biological/Adopted/Step	<input type="checkbox"/> Yes	<input type="checkbox"/> Lives with Family		
<input type="checkbox"/> Bachelor's	<input type="checkbox"/> Grade 11	<input type="checkbox"/> Part Time	<input type="checkbox"/> Part Time & Training	<input type="checkbox"/> Grandchild	<input type="checkbox"/> No	<input type="checkbox"/> Provides Financial Support		
<input type="checkbox"/> Col Deg/Train	<input type="checkbox"/> Grade 12	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Training or School	<input type="checkbox"/> Other Relative		<input type="checkbox"/> Teen Parent		
<input type="checkbox"/> Col or Adv Train	<input type="checkbox"/> < Grade 9	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Foster		If teen parent, subsidized?		
<input type="checkbox"/> GED	<input type="checkbox"/> HS Graduate			<input type="checkbox"/> Other		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Master's							
Email Address: _____								

Secondary or Other Adult								
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Enrollment ID
Race			Hispanic	English Proficiency	Other Language	Other Language Proficiency		
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native		<input type="checkbox"/> Yes	<input type="checkbox"/> Little		<input type="checkbox"/> Little		
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander		<input type="checkbox"/> No	<input type="checkbox"/> Moderate		<input type="checkbox"/> Moderate		
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial			<input type="checkbox"/> None		<input type="checkbox"/> None		
<input type="checkbox"/> Other: _____				<input type="checkbox"/> Proficient		<input type="checkbox"/> Proficient		
Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:		
<input type="checkbox"/> Associate's	<input type="checkbox"/> Grade 10	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full Time & Training	<input type="checkbox"/> Biological/Adopted/Step	<input type="checkbox"/> Yes	<input type="checkbox"/> Lives with Family		
<input type="checkbox"/> Bachelor's	<input type="checkbox"/> Grade 11	<input type="checkbox"/> Part Time	<input type="checkbox"/> Part Time & Training	<input type="checkbox"/> Grandchild	<input type="checkbox"/> No	<input type="checkbox"/> Provides Financial Support		
<input type="checkbox"/> Col Deg/Train	<input type="checkbox"/> Grade 12	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Training or School	<input type="checkbox"/> Other Relative		<input type="checkbox"/> Teen Parent		
<input type="checkbox"/> Col or Adv Train	<input type="checkbox"/> < Grade 9	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Foster		If teen parent, subsidized?		
<input type="checkbox"/> GED	<input type="checkbox"/> HS Graduate			<input type="checkbox"/> Other		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Master's							
Email Address: _____								

Additional Child (Non-Applicant) *								
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	
Race			Hispanic	English Proficiency	Other Language	Other Language Proficiency		
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native		<input type="checkbox"/> Yes	<input type="checkbox"/> Little		<input type="checkbox"/> Little		
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander		<input type="checkbox"/> No	<input type="checkbox"/> Moderate		<input type="checkbox"/> Moderate		
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial			<input type="checkbox"/> None		<input type="checkbox"/> None		
<input type="checkbox"/> Other: _____				<input type="checkbox"/> Proficient		<input type="checkbox"/> Proficient		

Additional Child (Non-Applicant) *								
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	
Race			Hispanic	English Proficiency	Other Language	Other Language Proficiency		
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native		<input type="checkbox"/> Yes	<input type="checkbox"/> Little		<input type="checkbox"/> Little		
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander		<input type="checkbox"/> No	<input type="checkbox"/> Moderate		<input type="checkbox"/> Moderate		
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial			<input type="checkbox"/> None		<input type="checkbox"/> None		
<input type="checkbox"/> Other: _____				<input type="checkbox"/> Proficient		<input type="checkbox"/> Proficient		

* If a family has more than one child applying for services, please complete a separate copy of this form for each applicant.



Mandan, Hidatsa, & Arikara Nation
Three Affiliated Tribes Head Start

Family Member Information

Applicant _____ Birthday _____

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN
Race			Hispanic	English Proficiency	Other Language	Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little			<input type="checkbox"/> Little	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate			<input type="checkbox"/> Moderate	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None			<input type="checkbox"/> None	
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient			<input type="checkbox"/> Proficient	

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN
Race			Hispanic	English Proficiency	Other Language	Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little			<input type="checkbox"/> Little	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate			<input type="checkbox"/> Moderate	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None			<input type="checkbox"/> None	
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient			<input type="checkbox"/> Proficient	

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN
Race			Hispanic	English Proficiency	Other Language	Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little			<input type="checkbox"/> Little	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate			<input type="checkbox"/> Moderate	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None			<input type="checkbox"/> None	
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient			<input type="checkbox"/> Proficient	

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN
Race			Hispanic	English Proficiency	Other Language	Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little			<input type="checkbox"/> Little	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate			<input type="checkbox"/> Moderate	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None			<input type="checkbox"/> None	
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient			<input type="checkbox"/> Proficient	

***If a family has more than one child applying for services, please complete a separate copy of this form for each applicant.**



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Three Affiliated Tribes Head Start**



No Income Statement

To whom it may concern,

I, _____ verify that I have no income at this time.
(Parent/Guardian's Name)

(Signature of Parent/Guardian)

(Date)



**Mandan, Hidatsa, & Arikara Nation
Three Affiliated Tribes Head Start**

This Section for Agency Use Only:

Family Information, Income & Contacts

Applicant Name: _____ Birthday: _____

Family Information									
Family Living Address									
Physical Address (No PO Box)					ZIP	City	State	County	
Segment (Circle One)									
Four Bears		Mandaree		New Town		Parshall		Twin Buttes	
Family Mailing Address									
Same as living? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Mailing Address					ZIP	City	State		
Phone Number(s)			Type (check one)			Parent/Guardian Name		Opt in for Text Messages	
			<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other					<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other					<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Parental Status (check one)	Primary Language at Home	Relationship to Participant(s)	Acquired/learning another language in addition to English	Homeless Family	Active Duty Military	Military Veteran	Referred by Child Welfare Agency	Receiving SNAP	WIC
<input type="checkbox"/> One <input type="checkbox"/> Two			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Family Income			
Income Verified by Staff Member		Verification Date	
Income Notes		TANF Status	SSI
		<input type="checkbox"/> Yes <input type="checkbox"/> Formerly on TANF/Not now	<input type="checkbox"/> Yes <input type="checkbox"/> No

Emergency Contacts										
Contact	Name			Relationship			Emergency Contact		Release To	
							<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physical Address (No PO Box)				ZIP		City			
Phone Number 1			Phone Number 2			Phone Number 3				
<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work			<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work			<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work				
Contact	Name			Relationship			Emergency Contact		Release To	
							<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physical Address (No PO Box)				ZIP		City			
Phone Number 1			Phone Number 2			Phone Number 3				
<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work			<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work			<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work				
Contact	Name			Relationship			Emergency Contact		Release To	
							<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physical Address (No PO Box)				ZIP		City			
Phone Number 1			Phone Number 2			Phone Number 3				
<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work			<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work			<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work				



**Mandan, Hidatsa, & Arikara Nation
Three Affiliated Tribes Head Start**

EMERGENCY CONTACT & DROP OFF/PICK UP

Applicant Name _____

Birthday _____

Contact	Name		Relationship	Emergency Contact	Release To
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physical Address (No PO Box)		ZIP	City	State
Phone		Phone Number 2	Phone Number 3		
<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	
Contact	Name		Relationship	Emergency Contact	Release To
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physical Address (No PO Box)		ZIP	City	State
Phone		Phone Number 2	Phone Number 3		
<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	
Contact	Name		Relationship	Emergency Contact	Release To
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physical Address (No PO Box)		ZIP	City	State
Phone		Phone Number 2	Phone Number 3		
<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	
Contact	Name		Relationship	Emergency Contact	Release To
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physical Address (No PO Box)		ZIP	City	State
Phone		Phone Number 2	Phone Number 3		
<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	
Contact	Name		Relationship	Emergency Contact	Release To
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physical Address (No PO Box)		ZIP	City	State
Phone		Phone Number 2	Phone Number 3		
<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	
Contact	Name		Relationship	Emergency Contact	Release To
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physical Address (No PO Box)		ZIP	City	State
Phone		Phone Number 2	Phone Number 3		
<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	

No registered sex offender will be eligible to Drop off or Pick up children, this also includes a parent or guardian. A person that's dropping off or picking up children must be the age of 18 years or older and will be subject to provide identification as needed.

Certification: I certify that 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 that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent/Guardian Signature: _____ Date: _____

Interviewer Signature: _____ Date: _____



**Mandan, Hidatsa, & Arikara Nation
Three Affiliated Tribes Head Start**



Child Demographics

The following questions are being asked so that we may better serve our Head Start children and their families as well as to comply with Head Start regulation.

Head Start regulation *45CFR 1305.6(c)* states that a least 10% of enrollment opportunities must be made available to children with disabilities.

1. Indicate if child has been identified as having or is suspected as having any of the following so that we may meet the needs of the child. Please fill in all appropriate information.

Parent report and records indicate no disabilities.

	Suspected	Identified	Date	Evaluated by
Autism				
Emotional/Behavior Disorder				
Health Impairment				
Learning Disability				
Mental Retardation				
Orthopedic Impairment				
Speech or Language Impairment				
Traumatic Brain Injury				
Visual Impairment including Blindness				
Other				

Family Circumstance

2. Please indicate any issues which have occurred to you child's immediate family.

Within the last 2 Years

- Child abuse or neglect
- Death in the family
- Domestic Violence
- Divorce
- Drug and Alcohol Abuse
- Military Deployment
- Incarceration of parent/guardian
- Homelessness (includes families living temporarily in shelter, hotels, or vehicles; moving frequently between homes of relatives and friends)

Currently

- Child is in foster care
- Child is not in foster care, but is not living with a biological or adoptive parent
- Only one adult lives in the home.
- Parent/Guardian is receiving disability payments
- Other: _____

3. Why would you like your child to be considered for Head Start?

Medical Screenings Consent



Child's Name: _____ Circle One: **Returning Student**
New Student

Medical Insurance: Yes Specify: _____
 No

By signing below you are granting permission for your child (As named above) to participate in the screening done for that specified medical area:

- A1C
- Blood Pressure
- Brigrance
- Dental
- Hearing
- Height/Weight
- Hemoglobin
- Head Circumference
- Lead
- Vision

(Parent/Guardian Signature)

(Date)

****The Three Affiliated Tribes Head Start Program partners and shares information with Elbowoods Memorial Health Center and the TAT Infant & Toddler Program.**



**Mandan, Hidatsa, & Arikara Nation
Three Affiliated Tribes Head Start**



Child Nutritional Assessment

Date Completed: _____

Child's Name: _____ Date of Birth: _____

Eating Frequency (times per day): _____

Dietary Habits: _____

Favorite Foods: _____

Least Favorite Foods: _____

- Child takes vitamin/mineral supplements?
 - Supplements contain iron?
 - Supplements contain fluoride?
 - Supplements were prescribed?

Foods not eaten for medical, religious or personal reasons?

Child on a special diet?

Change in child appetite in the past month?

Child takes a bottle?

Child eats or chews things that aren't food?

Child has trouble chewing or swallowing?

Child often has:

Diarrhea

Constipation

Concerns about what the child eats?

Yes

Comments:

-
-
-
-
-
-
-
-
-
-
-
-
-
-
-

Usual Food Group Eating Frequency:

Approximate Number of times each week

A. Milk, Cheese, Yogurt	0	1	2	3	4	5	6	7+
B. Meat, Poultry, fish, eggs, or dried beans/peas. peanut butter	0	1	2	3	4	5	6	7+
C. Rice, grits, bread, cereal, tortillas	0	1	2	3	4	5	6	7+
D. Greens, carrots, broccoli, water squash, pumpkin, sweet potatoes	0	1	2	3	4	5	6	7+
E. Orange, grapefruit, tomatoes, (fruit/juice)	0	1	2	3	4	5	6	7+
F. Other fruit and vegetables	0	1	2	3	4	5	6	7+
G. Oil, butter, margarine, lard	0	1	2	3	4	5	6	7+
H. Cakes, cookies, sodas, fruit drinks, candies	0	1	2	3	4	5	6	7+

CACFP Enrollment Form / Free and Reduced-Price Income Application (Child Care)

Center Name

Complete one application per household. Please use a pen (not a pencil).

STEP 1 REQUIRED - The parent / guardian must complete Parts 1 and 4. List ALL Children who attend day care

CHILD'S Last Name, First Name	Date of Birth	Time of Care		Regular Days of Care							Meals Served During Care				Foster Child	Migrant	Head Start										
		Arrival Time	Leave Time	M	T	W	T	F	S	S	B	A	M	L				P	M	D	E	V					
		8:30 AM	3:30 PM	✓	✓	✓	✓	✓						✓													

Check all that apply

PARENTS OF INFANTS Your child care center must offer at least one brand of formula if your child is on formula. You have the option of declining that brand and supplying your own formula. Children must be served breast milk or iron-fortified infant formula until they are one year of age. All other food items must be provided by your center when age-appropriate, consistent with CACFP guidelines.

My Choice of CACFP Infant Participation is:
 I choose to supply expressed breast milk to my child care provider to serve at meal time.
 I choose to accept the iron-fortified infant formula (brand: _____) that my child care center has offered.
 My child care center has offered the following brand: _____ I have chosen to decline this brand and provide the formula for my infant.

STEP 2 Optional - Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDIPIR?

IF NO > Go to STEP 3 IF YES > Write case number here and proceed to STEP 4 (do not complete STEP 3) **CASE NUMBER:** _____ Write only one case number in this space.

STEP 3 Optional - Parent / guardian should fill out household income to determine the amount of CACFP funds the center will be eligible to receive. This form will be placed in our confidential files.

A. Child Income
 Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

B. All Other Household Members (including yourself)
 List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Household Members not listed in Step 1 (Last Name, First Name)	Earnings from Work		How often?		Welfare/Child Support/Alimony		How often?		Pensions/Retirement/Social Security/SSI/VA Benefits		How often?	
	Weekly	Bi-Weekly	Monthly	Bi-Monthly	Weekly	Bi-Weekly	Monthly	Bi-Monthly	Weekly	Bi-Weekly	Monthly	Bi-Monthly
	\$				\$				\$			
	\$				\$				\$			
	\$				\$				\$			
	\$				\$				\$			
	\$				\$				\$			

Total Household Members (Children and Adults) _____ Last Four Digits of Social Security Number (SSN) of Primary-Wage Earner or other Adult Household Member _____

STEP 4 REQUIRED - Sign and date the application. The form must be signed by the parent or guardian.

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form _____ Signature of Adult _____ Today's Date _____

Address _____ City _____ State _____ Zip _____ Phone/Email _____

NOT NEEDED



Parent Report—Self-help and Social-Emotional Scales

Child's Name _____ Child's Date of Birth _____ Today's Date _____
 Parent's/Caregiver's Name _____ Teacher's Name _____

Directions: Read each item and circle the response or description that best reflects your child's behavior or skill level.

SELF-HELP SKILLS	
A. Eating Skills	
1. Does your child use a spoon? If yes, does your child place the spoon in his/her mouth without turning the spoon upside down, with little or no spilling of food?	Rarely/No Sometimes Most of the time
2. Does your child use the side of the fork for cutting soft food, such as a piece of baked potato or a piece of cake?	Rarely/No Sometimes Most of the time
3. Does your child hold a fork in his/her fingers, not in his/her fist?	Rarely/No Sometimes Most of the time
B. Dressing Skills	
4. Does your child put on his/her shoes? Criteria: Buckling, tying, or Velcro® fastening is not required for credit.	No Yes (sometimes on wrong feet) Yes (each shoe on correct foot 90% of the time)
5. Does your child dress himself/herself unsupervised?	Rarely/No Sometimes Most of the time, except for help with difficult fasteners
	Yes (completely dresses himself/herself, putting all clothes on correctly and fastening all fasteners) Yes (completely dresses himself/herself, including tying shoelaces and fastening all fasteners)
6. Does your child put on his/her socks?	Rarely/No Sometimes Most of the time

C. Toileting Skills	
7. Does your child get on the toilet or potty by himself/herself (even if he/she needs help with clothing)?	Rarely/No Sometimes Most of the time
8. Does your child have bowel movements ("poop") in the toilet or potty (no more than one accident a week)?	Rarely/No Sometimes Most of the time
9. Does your child urinate ("pee") in the toilet or potty (no more than one accident a week)?	Rarely/No Sometimes Most of the time
10. Does your child attempt to wipe himself/herself after toileting?	Rarely/No Sometimes Most of the time
OR	
Does your child wipe himself/herself independently after toileting?	Rarely/No Sometimes Most of the time
11. Does your child take care of his/her toileting needs?	Rarely/No Sometimes Most of the time
	Rarely/No Sometimes Yes (flushing the toilet most of the time after using it) Yes (flushing the toilet and washing and drying his/her hands most of the time)
12. Does your child go to the bathroom on his/her own without being asked or reminded?	Rarely/No Sometimes Most of the time

Parent Report—Self-help and Social-Emotional Scales (continued)

SOCIAL AND EMOTIONAL SKILLS

D. Relationships with Adults

13.	Does your child respond with feelings of pride and enthusiasm when he/she earns positive feedback?	Rarely/No	Sometimes	Most of the time
14.	Does your child look forward to sharing his/her feelings with you when he/she is happy?	Rarely/No	Sometimes	Most of the time
15.	Does your child enjoy sharing information with you about himself/herself, such as things he/she likes, names of his/her family members or pets, or what he/she did over the weekend?	Rarely/No	Sometimes	Most of the time
16.	Does your child share his/her thoughts and ideas with you?	Rarely/No	Sometimes	Most of the time

E. Play and Relationships with Peers

17.	Does your child have several friends but one who is a special or best friend?	No	Yes	
18.	Does your child have a best friend with whom he/she is close and who reciprocates by coming over for play dates or extending an invitation to a party?	No	Yes	
19.	Does your child play cooperatively in a large-group game, such as duck-duck-goose, tag, or kickball?	Rarely/No	Sometimes	Most of the time
20.	Does your child give verbal directions or incorporate verbal directions into play activities?	Rarely/No	Sometimes	Most of the time

F. Motivation and Self-Confidence

21.	Does your child maintain interest when engaged in a small-group activity or project?	Rarely/No	Sometimes	Most of the time
22.	Does your child show that he/she likes to finish what he/she starts, perhaps by dawdling less than at an earlier age?	Rarely/No	Sometimes	Most of the time
23.	Does your child approach new tasks with confidence and a "can-do" attitude?	Rarely/No	Sometimes	Most of the time
24.	Does your child remain focused on what he/she has been asked to do even when there are minor distractions, such as a car making noise outside or someone tapping a pencil?	Rarely/No	Sometimes	Most of the time

G. Prosocial Skills and Behaviors

25.	If supervised by an adult, does your child take turns without undue objection?	Rarely/No	Sometimes	Most of the time
26.	Does your child understand or accept the need to share and take turns, perhaps willingly taking turns even if he/she isn't asked to?	Rarely/No	Sometimes	Most of the time
27.	Does your child ask an adult for permission before using things that belong to others or before engaging in an activity that may be restricted, such as going to the bathroom or leaving the classroom?	Rarely/No	Sometimes	Most of the time
28.	Does your child react to a disappointment or failure in an acceptable manner by being a good sport and refraining from shouting or getting upset?	Rarely/No	Sometimes	Most of the time

Child Physical Exam-Three Affiliated Tribes Head Start

Note: To be filled out by parent:

Date: ___/___/___

Child's Name: _____ Date of Birth _____

Parent/Guardian Name: _____

Provider Setting: Doctor/Clinic School/Center Other: Specify _____

Medical Insurance: No Yes Specify: _____

Has or does your child experience any of the following (check all that apply):

Asthma Allergic Reactions Physical/Learning Disability None

Food Allergies: _____

Medicine Allergies: _____

Medications Taking: _____

Note: To be filled out by Medical Provider:

Ht: _____ Wt: _____ BP: _____ Head Circumference: _____ HGB: _____ A1C: _____

Lead Screening:

Result: _____

Vision Screening:

Right Eye _____ Left Eye _____ Both _____

Hearing Screening:

Right Ear (Circle one): PASS or FAIL Left Ear (Circle one): PASS or FAIL

Dental Screening:

Dental Caries: _____

Child Physical Exam-Three Affiliated Tribes Head Start

Physical Exam/Assessment:

Physical Examination	Normal	Abnormal	Needs Y/N	Physical Examination	Normal	Abnormal	Needs Y/N
General Appearance				Heart			
Posture/Gait				Lungs			
Head				Abdomen (Include Hernia)			
Skin				Bones, Joints, Muscles			
Eyes External Aspects				Muscular Coordination			
Ears External Canal				Gross Motor			
Nose, Mouth, Pharynx				Fine Motor			
Glands (Lymphatic/Thyroid)				Cognitive			
Communication Skills				Self-Help Skills			
Speech							

Comments/Findings/Observations/Referral:

Determined to be up-to date on a schedule of age appropriate preventive and primary health care which includes medical, dental and mental health as per ND EPSDT guidelines Yes No HSPS 1304.20(a)(ii)

Provider Signature: _____ Date: ___/___/___

(Print) Provider Name: _____