Mandan, Hidatsa, Arikara Nation

HEAD START ENROLLMENT

APPLICATION 2026-2027

NEW STUDENTS

- Application - Filled out completely
- **Birth Certificate** (Copy)
- Tribal Enrollment/ID (Extra 50pts)
- Income Documentation - Copy of pay stub/direct deposit, W-2, Employer Statement, Letter or Contract
- Physicals & Blood Work **(HGB, A1C & Lead)** Required before school starts. **(To be done no earlier than May 28th)**
- Copy of Medical/State, Medicaid/Dental Insurance Cards
- Immunizations

RETURNING STUDENTS

- Application - Filled out completely
- Income Documentation **(Updated Required)**
- Physical & Blood Work **(HGB & A1C)** Required before school starts. **(To be done no earlier than May 28th)**
- Copy of Medical/State, Medicaid/Dental Insurance Cards
- Updated Immunizations

THIS IS A FEDERAL APPLICATION AND MUST BE COMPLETED ACCURATELY AND HONESTLY. ALL INFORMATION PROVIDED SHOULD BE TRUE AND UP TO DATE.
(IF PRINTING/SCANNING DOCUMENTS PLEASE KEEP THEM TO ONE SIDED)

Mandan, Hidatsa, & Arikara Nation
Three Affiliated Tribes Head Start
509 9th Street North
New Town, ND 58763
(701) 627-4820 Fax (701) 627-4401

Parent and Family Engagement Policy

Head Start Performance Standard 1302.34 (a, b1-9)

According to our Head Start Performance Standard 1302.34 Parent and Family Engagement in Education and Child Development Services, our program must structure education and child development services to recognize parents' roles as children's lifelong educators, and to encourage parents to engage in their child's education.

Upon acceptance, the legal guardian will receive a written notice and/or complimentary phone call. The following events are mandatory.

- The legal guardian must participate in an **Initial Home Visit** before the student's start date. During this home visit, the legal guardian and the classroom staff will discuss and create goals according to the family's needs. These goals will be revisited and monitored throughout the school year. Attending the **Transition Home Visit** at the end of the year is also required.
- The legal guardian must attend and complete a scheduled **Parent Orientation** to review the program's policies and procedures.
- The legal guardian is also required to attend **Parent-Teacher Conferences** that are scheduled no less than 2x per program year. These are to enhance the knowledge and understanding of both staff and parents of the child's education and development progress, and activities in the program.

These events are required by our program to ensure the family's understanding of our daily operations, policies, and procedures to promote school readiness and healthy habits for their students.

If multiple documented attempts have been made, failure to attend these events may result in your student being placed on the waiting list, and their slot may be offered to other applicants

The Three Affiliated Tribes Head Start Program warmly welcomes families to be actively involved in their child's development and educational journey. We strongly encourage parents to contribute at least one hour each month by taking part in various activities such as Monthly Parent Meetings, Family Education Nights, Parent Trainings, and volunteering opportunities.

- ☐ **I have reviewed and acknowledge my responsibilities outlined in the Parent and Family Engagement Policy.**

Parent-Legal Guardian Name (print) & Signature:

_____

Date:

_____

Applicant & Family Member Information

Applicant

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Enrollment #

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
☐ Yes
☐ No

English Proficiency
☐ Little
☐ Moderate
☐ None
☐ Proficient

Other Language

Other Language Proficiency
☐ Little
☐ Moderate
☐ None
☐ Proficient

Primary Health Coverage	Other Coverage	Insurance #	Medicaid Eligibility	Medicaid #	Doctor/Medical Home
			☐ Not Eligible ☐ On Medicaid ☐ Potentially		

Dental Coverage	Dental Coverage #	Dentist/Dental Home

Primary Adult

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Enrollment ID

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
☐ Yes
☐ No

English Proficiency
☐ Little
☐ Moderate
☐ None
☐ Proficient

Other Language

Other Language Proficiency
☐ Little
☐ Moderate
☐ None
☐ Proficient

Highest Grade Completed
☐ Associate's
☐ Bachelor's
☐ Col Deg/Train
☐ Col or Adv Train
☐ GED
☐ Grade 10
☐ Grade 11
☐ Grade 12
☐ < Grade 9
☐ HS Graduate
☐ Master's

Employment Status
☐ Full Time
☐ Part Time
☐ Seasonal
☐ Unemployed
☐ Full Time & Training
☐ Part Time & Training
☐ Training or School
☐ Retired or Disabled

Child's Relationship
☐ Biological/Adopted/Step
☐ Grandchild
☐ Other Relative
☐ Foster
☐ Other

Custody
☐ Yes
☐ No

Check all that apply:
☐ Lives with Family
☐ Provides Financial Support
☐ Teen Parent

If teen parent, subsidized?
☐ Yes ☐ No

Email Address:

Secondary or Other Adult

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Enrollment ID

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
☐ Yes
☐ No

English Proficiency
☐ Little
☐ Moderate
☐ None
☐ Proficient

Other Language

Other Language Proficiency
☐ Little
☐ Moderate
☐ None
☐ Proficient

Highest Grade Completed
☐ Associate's
☐ Bachelor's
☐ Col Deg/Train
☐ Col or Adv Train
☐ GED
☐ Grade 10
☐ Grade 11
☐ Grade 12
☐ < Grade 9
☐ HS Graduate
☐ Master's

Employment Status
☐ Full Time
☐ Part Time
☐ Seasonal
☐ Unemployed
☐ Full Time & Training
☐ Part Time & Training
☐ Training or School
☐ Retired or Disabled

Child's Relationship
☐ Biological/Adopted/Step
☐ Grandchild
☐ Other Relative
☐ Foster
☐ Other

Custody
☐ Yes
☐ No

Check all that apply:
☐ Lives with Family
☐ Provides Financial Support
☐ Teen Parent

If teen parent, subsidized?
☐ Yes ☐ No

Email Address:

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
☐ Yes
☐ No

English Proficiency
☐ Little
☐ Moderate
☐ None
☐ Proficient

Other Language

Other Language Proficiency
☐ Little
☐ Moderate
☐ None
☐ Proficient

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
☐ Yes
☐ No

English Proficiency
☐ Little
☐ Moderate
☐ None
☐ Proficient

Other Language

Other Language Proficiency
☐ Little
☐ Moderate
☐ None
☐ 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

Student Name:______________________
Birthday:______________________

Family Member Information

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little		☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: ______________			☐ Proficient		☐ Proficient

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little		☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: ______________			☐ Proficient		☐ Proficient

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little		☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: ______________			☐ Proficient		☐ Proficient

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little		☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: ______________			☐ Proficient		☐ 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

Student Name______________________________

Birthday:______________________________

Family Information, Income & Contacts

Family Information

Family Living Address

Physical Address (No PO Box)	ZIP	City	State	County

Segment (Circle One)

Four Bears   Mandaree   New Town   Parshall   White Shield   Twin Buttes

Family Mailing Address

Same as living?		Mailing Address	ZIP	City	State
☐ Yes ☐ No					

Phone Number(s)	Type (*check one*)	Parent/Guardian Name	Opt in for Text Messages
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ 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
☐ One ☐ Two			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Ye ☐ No

Family Income

Income Verified by Staff Member	Verification Date	TANF Status	SSI
		☐ Yes ☐ No ☐ Formerly on TANF/Not now	☐ Ye ☐ No

Income Notes

Emergency Contacts

Contact

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Physical Address (No PO Box)	ZIP	City	Stat

Phone Number 1	Phone Number 2	Phone Number 3
☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Wo

Contact

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Physical Address (No PO Box)	ZIP	City	Stat

Phone Number 1	Phone Number 2	Phone Number 3
☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Wo

Contact

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Physical Address (No PO Box)	ZIP	City	Stat

Phone Number 1	Phone Number 2	Phone Number 3
☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Wc

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

EMERGENCY CONTACT DROP OFF/PICK UP FORM

Student Name: _____

Birthday: _____

Emergency Contact & Pick Up/Drop Off

	Name	Relationship	Emergency Contact	Release To
Contact 1			☐ Yes ☐ No	☐ Yes ☐ No
Contact 2			☐ Yes ☐ No	☐ Yes ☐ No
Contact 3			☐ Yes ☐ No	☐ Yes ☐ No
Contact 4			☐ Yes ☐ No	☐ Yes ☐ No

	Physical Address (No P.O. BOX)	ZIP	City	State
Contact 1				
Contact 2				
Contact 3				
Contact 4				

	Phone Number 1	Phone Number 2	Phone Number 3
Contact 1	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work
Contact 2	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work
Contact 3	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work
Contact 4	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work

No registered sex offender will be eligible to Drop off or Pick up child(ren) this also includes a parent or guardian. A person that's dropping off or picking up child(ren) must be the age of 18 years or older and will be subject to provide an 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: _____

Revised 04/15/2026

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?

Mandan, Hidatsa, & Arikara Nation
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) I will inform staff if that changes at any time.

_____ _____
(Signature of Parent/Guardian) (Date)

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**
- **Brigance**
- **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: _____

_____

	Yes	Comments:
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?	☐	

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+

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	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

NORTH DAKOTA DEPARTMENT OF
PUBLIC INSTRUCTION

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

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

Center Name: ____________________

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: Arrival Time	Time of Care: Leave Time	Regular Days of Care: M	T	W	T	F	S	S	Meals Served During Care: B	AM	L	PM	D	EV	Check all that apply: Foster Child	Migrant	Head Start
[redacted]		8:30am	3:30 pm	✓	✓	✓	✓	✓			✓		✓	✓					

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 FDPIR?

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.

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The "Sources of Income for Children" chart will help you with the Child Income section.

The "Sources of Income for Adults" chart will help you with All Adult Household Members section.

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.

Child Income	How often? Weekly	Bi-Weekly	Monthly	Bi-Monthly
$	○	○	○	○

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? Weekly	Bi-Weekly	Monthly	2x Month	Welfare/Child Support/Alimony	How often? Weekly	Bi-Weekly	Monthly	2x Month	Pensions/Retirement/Social Security/SSI/VA Benefits	How often? Weekly	Bi-Weekly	Monthly	2x Month
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults) [ ][ ]

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member: X X X – X X – [ ][ ][ ][ ]

Check if no SSN ☐

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

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: _____