



2096 Red Arrow Trail
Madison, WI 53711

Tel: (608) 275-6740

Fax: (608) 275-6756

www.reachdane.org

Application for Enrollment

Head Start Early Head Start Child Care

Dear Parent/Guardian:

Thank you for your interest in Reach Dane! Reach Dane is a federally funded agency that provides Head Start and Early Head Start services for low income families in Dane and Green counties. Reach Dane provides high-quality early childhood services to children ages 0-5 through center-based and home-based programs.

Proof of income is required to determine eligibility for Head Start and Early Head Start and is a part of the application process. Please complete the attached application and submit it and proof of income to:

Reach Dane
2096 Red Arrow Trail
Madison, WI 53711
Attn: Enrollment

You can also fax the application and proof of income to (608) 275-6756 Attn: Enrollment

Examples of Acceptable Income Forms:

- A copy of your 2023 Federal Tax return
- 2023 W-2 Tax Statements from all employers
- Paycheck stub from current employer
(if you have been at your job for more than 1 year)
- SSI Documentation
- Unemployment Payment
- Child Support
- W-2 (Wisconsin Works) Paperwork
- Foster Care/Kinship Care Placement for the Enrolling Child
- SNAP (Food Share Benefits)

Please call us at (608) 275-6740 if you have any questions or concerns!

Please note that applications are processed throughout the program year. Please contact us with any changes in address and/or phone number so we are able to contact you. Thank you for your interest in Head Start/Early Head Start!

Sincerely,

"Reach Dane changes the lives of underserved children and families through educational and supportive services"

2096 Red Arrow Trail
Madison, WI 53711

APPLICATION FOR ENROLLMENT

Head Start, Early Head Start, & Child Care

Phone: 608-275-6740

Fax: 608-275-6756

www.reachdane.org

Acceptance to Head Start and Early Head Start is based on the income and needs of the child/family and NOT first-come first-served

Primary Applicant: *please Check the box* **Pregnant Mother** **Child**

CHILD INFORMATION:

Child's Legal Name (Last): _____ (First): _____ (Middle): _____

Date of Birth: ____ mo. ____ day ____ year **Gender:** Male Female **Social Security #:** _____ - ____ - _____

Race of Child: *Check all* American Indian or Alaska Native Asian Black/African American

That Apply Native Hawaiian/Pacific Islander White Bi-Racial/Multi Racial Other (specify): _____

Ethnicity: Hispanic/Latino Non-Hispanic/Latino

Child's Primary Language: English Spanish Hmong Other (Specify): _____

Speaks English: Proficient Moderate Little None

Does your child receive Medical Assistance? Yes No **MA/Forward ID Number:** _____

Does your child have private insurance? Yes No **Company:** _____

Is this child currently in Early Head Start? Yes No **If yes, who is your Family Advocate?** _____

Living Address: _____ **City:** _____ **Zip Code:** _____

Mailing Address *(if different than living address):* _____ **City:** _____ **Zip Code:** _____

Child Lives With: Both Parents Mother Father Foster Care Guardian Other *specify:* _____

Primary Parent/Guardian Name: (Last): _____ (First): _____ **Date of Birth:** _____

Relationship to Child *(please check)* : Mother Father Stepparent Foster Parent Guardian Other *specify:* _____

Address *(if different than child's):* _____ **City:** _____ **Zip Code:** _____

Phone Number: **Home:** _____ **Cell:** _____ **Work:** _____

How do you prefer we contact you? *Check all that apply* Phone Call Text Email

Social Security #: _____ - ____ - _____ **Email Address:** _____

Currently Pregnant? Yes No N/A **If yes, due date:** _____ **Do you have medical coverage/health insurance?** Yes No

Race: *Check all* American Indian or Alaska Native Asian Black/African American Native Hawaiian/Pacific Islander White

That Apply Bi-Racial/Multi Racial Other (specify): _____ **Ethnicity:** Hispanic/Latino Non-Hispanic/Latino

Primary Language: English Spanish Hmong Other (Specify): _____

Speaks English: Proficient Moderate Little None **Currently in the Military or Military Veteran?** Y N

Highest Grade Completed: Grade _____ High School Graduate GED HSED Some College Associates Bachelor Masters

Secondary Parent/Guardian Name: (Last): _____ (First): _____ **Date of Birth:** _____

Relationship to Child *please check* : Mother Father Stepparent Foster Parent Guardian Other *specify:* _____

Address *(if different than child's):* _____ **City:** _____ **Zip Code:** _____

Phone Number: **Home:** _____ **Cell:** _____ **Work:** _____

How do you prefer we contact you? *Check all that apply* Phone Call Text Email

Social Security #: _____ - ____ - _____ **Email Address:** _____

Currently Pregnant? Yes No N/A **If yes, due date:** _____ **Do you have medical coverage/health insurance?** Yes No

Race: *Check all* American Indian or Alaska Native Asian Black/African American Native Hawaiian/Pacific Islander White

That Apply Bi-Racial/Multi Racial Other (specify): _____ **Ethnicity:** Hispanic/Latino Non-Hispanic/Latino

Primary Language: English Spanish Hmong Other (Specify): _____

Speaks English: Proficient Moderate Little None **Currently in the Military or Military Veteran?** Y N

Highest Grade Completed: Grade _____ High School Graduate GED HSED Some College Associates Bachelor Master

Marital Status of Parent(s) *(please check):*

- Married Divorced Separated Widowed
- Never Married: Living Together
- Never Married: Not Living Together

Current Living Situation *(please check):*

- Rent Own
- Or Living with:
- Family Friends Shelter
- Other Homelessness *(describe):* _____

Total # of **OTHER** people living in your household. **INCLUDE ALL SIBLINGS:** _____ *attach paper if more space is needed*

1. Name: _____ DOB: _____ Sex: M F
 Relationship to applicant: _____ Any Income? Y N *(If yes, please specify)* _____
2. Name: _____ DOB: _____ Sex: M F
 Relationship to applicant: _____ Any Income? Y N *(If yes, please specify)* _____
3. Name: _____ DOB: _____ Sex: M F
 Relationship to applicant: _____ Any Income? Y N *(If yes, please specify)* _____
4. Name: _____ DOB: _____ Sex: M F
 Relationship to applicant: _____ Any Income? Y N *(If yes, please specify)* _____

Birth History:

- Is this your first pregnancy? *(please check)* Yes No
- Have you/did you receive regular prenatal care during this pregnancy? Yes No
- Which month was your first prenatal visit? *(please check)* 1 2 3 4 5 6 7 8 9
- Is/Was your pregnancy determined to be High Risk by a doctor or health care provider? Yes No
- Are you currently seeing a Public Health Nurse or PNCC? Yes No

- Is the applicant child in childcare now? *(please check)* Yes No What hours is child in care? _____
- Do you have child care subsidy from *(please Check):* County City How much is your weekly co-pay? _____
- Type of care *(please check)?* Center Family Day Care Friend Family Member
- Address/Location? _____
- Interested in full-day child care with us? *(please check):* Yes No Days & hours you need care: _____

Does the applicant child have a **diagnosed** disability? Yes No

Describe the diagnosed disability: _____

Does your child have Individualized Education Plan or Individualized Family Support Plan? IEP IFSP

Is an IEP or IFSP underway for this child? Yes No

Does your child receive any special services from a public school or Birth-3 agency? Yes No

Name of Public School: _____

If yes, which of the following special services?

- Speech/Language Early Childhood Education Physical Therapy Occupational Therapy

Does your child have a **suspected** disability? Yes No

Describe the suspected disability: _____

Does anyone else in your family have a diagnosed or suspected disability? Yes No

Who? (Describe): _____

IMPORTANT!

Detailed answers to these questions help us determine placement.

Each answer is evaluated and contributes to the overall need of the child and family.

(If you need more writing space, you may attach a separate piece of paper with your answers and child's name & date of birth written at the top)

1. How did you hear about Us? *please check* Birth to 3 School Human Services Doctor/Nurse WIC Flyer
 Newspaper Ad Internet Search Friend or Family Member Other: *please explain* _____

2. What program are you interested in for this child? *please check all that you are interested in*

Home-Based Early Head Start (Pregnant Mother, 0-3 years)

Home-Based Head Start (3-5years)

Center-Based Early Head Start (6 weeks-3 years) *child care subsidy required

Part-Day Head Start (3-5years)

Infant/Toddler Child Care (6 weeks-3 years) *private pay or child care subsidy

Extended-Day (3-5 years) *limited transportation

Full-Day Head Start (3-5 years) *child care subsidy required, no transportation provided

For Head Start: Address for Bus Pick-Up: _____ Address for Bus Drop-Off: _____

Are you able to provide transportation for your child? Y N *Note: transportation is limited by service area*

3. Are you currently experiencing or did you experience any health problems or complications during this pregnancy, delivery, or after birth?

4. How long did the child stay in the hospital at birth?

5. Were there any problems or concerns at your child's birth or in his/her early development? (Please specify)

6. What are your current concerns about your child? (Health, development, speech, taking medication, etc. Please Specify)

7. How would you describe your child's behavior? Any concerns? (Please specify)

8. Have any major things happened to affect your child? (Homelessness, family violence, foster care, neglect, incarceration, death of family member, etc., please describe)

9. Do you have any concerns about providing for your family's basic needs? (Clothing, housing, food, financial, employment, etc..., please specify)

10. Does anyone in your immediate family have health, dental, nutrition, or mental health concerns? (Please specify)

11. Are there any other concerns you have for any family members? (Parenting skills, drug or alcohol issues, please specify)

12. What are your current child care needs? (child care to meet work schedule not available and/or not affordable, please explain)

13. Do you receive any of the following services? *Check all that apply* Subsidized Housing FoodShare WIC

APPLICATIONS CANNOT BE PROCESSED WITHOUT PROOF OF ALL FAMILY INCOME DURING THE LAST 12 MONTHS

Current Employment Status of Primary Parent/Guardian <i>please check</i>	Current Employment Status of Secondary Parent/Guardian <i>please check</i>
<input type="checkbox"/> Full-Time (35 hrs/wk or more) <input type="checkbox"/> Full-Time & Training <input type="checkbox"/> Part-Time (under 35 hrs/wk) <input type="checkbox"/> Part-Time & Training <input type="checkbox"/> Retired or Disabled <input type="checkbox"/> Seasonally Employed <input type="checkbox"/> Training or School <input type="checkbox"/> Unemployed <input type="checkbox"/> Unemployed & Training	<input type="checkbox"/> Full-Time (35 hrs/wk or more) <input type="checkbox"/> Full-Time & Training <input type="checkbox"/> Part-Time (under 35 hrs/wk) <input type="checkbox"/> Part-Time & Training <input type="checkbox"/> Retired or Disabled <input type="checkbox"/> Seasonally Employed <input type="checkbox"/> Training or School <input type="checkbox"/> Unemployed <input type="checkbox"/> Unemployed & Training
If Currently Employed, Date Started Job: _____	If Currently Employed, Date Started Job: _____
Employer Name: _____	Employer Name: _____
Gross Income: \$ _____	Gross Income: \$ _____
Paid (Check One): <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Other <i>specify:</i> _____	Paid (Check One): <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Other <i>specify:</i> _____
If at current job LESS THAN ONE YEAR or UNEMPLOYED list dates of employment for the last 12 months:	If at current job LESS THAN ONE YEAR or UNEMPLOYED list dates of employment for the last 12 months:
Employer: _____	Employer: _____
Start Date: _____ End Date _____	Start Date: _____ End Date _____
Employer: _____	Employer: _____
Start Date: _____ End Date _____	Start Date: _____ End Date _____
Unemployment Benefits \$ _____	Unemployment Benefits \$ _____
Per (check one): <input type="checkbox"/> Week <input type="checkbox"/> 2 Weeks <input type="checkbox"/> Month	Per (check one): <input type="checkbox"/> Week <input type="checkbox"/> 2 Weeks <input type="checkbox"/> Month
Date Unemployment Benefits Started: _____	Date Unemployment Benefits Started: _____

PLEASE CHECK IF YOU RECEIVE ANY OF THE FOLLOWING:

Foster Care or Kinship Care **for this child** Amount Received: \$ _____

Supplemental Security Income (SSI) Amount Received \$ _____

TANF (W-2 Cash Benefits) Amount Received \$ _____

Child Support Amount Received \$ _____ per (check one) Week 2 Weeks Month

Other Income: (check all that apply) school grants/scholarships military income social security benefits
 disability benefits other *specify:* _____

Amount Received \$ _____ per (check one) Week 2 Weeks Month Semester Other (specify) _____

Early Head Start and Head Start acceptance is based on the income and needs of the family/child, not on a first-come, first-served basis.

“I certify that the answers provided on this form are accurate and complete to the best of my knowledge. I understand that providing false information to a Federally-Funded Program is against the law. I am this child’s parent/guardian and this is our family’s income.”

Parent/Guardian Signature (required): _____ **Date:** _____

Reach Dane/Reach Green is a non-profit corporation. It does not discriminate in the administration of its programs.

Help keep your information up-to-date by notifying us of any changes at (608) 275-6740.

Agency Use Only
 PY: _____
 Date Entered: _____
 Entered By: _____

CONFIDENTIAL INFORMATION RELEASE AUTHORIZATION

Completion of this form authorizes the release of information described in the section below called "Specific Description of Records Authorized for Release." The person (record subject) whose records are released may have a right to inspect and, upon paying any applicable fees, obtain a copy of the disclosed records. Except for medication / somatic treatment records, a director / designee of a treatment facility for mental illness, developmental disability, alcohol or drug abuse may deny that right during treatment in some circumstances. Section 51.30, Wis. Stats., DHS 92.03-92.06 Wis. Adm. Code.

Person Whose Records Will Be Released (Record Subject) (child)

Name	Identifying Number (If Any)	Date of Birth
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Address (Street address or PO Box, City, State, Zip Code)

Agency / Organization I Authorize to Release Information

Name
DANE COUNTY HUMAN SERVICES

Address (Street address or PO Box, City, State, Zip Code)
1819 Aberg Ave, Madison, WI 53704

Information May Be Released To

Name	Organization Dane County Parent Council-Reach Dane
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Address (Street address or PO Box, City, State, Zip Code)
2096 Red Arrow Trl, Fitchburg, WI 53711

Specific Description of Records Authorized for Release (Include dates of records, if applicable)

All records are pertinent to the Reach Dane program participants the information that can be shared between the agencies is:

1. Case status
2. Approved activity for parent or caretaker
3. Information that would help the parent/caretaker to secure Wisconsin Share benefits.
4. Any other pertinent information that would help to expedite the Wisconsin Shares eligibility--please explain in detail.
5. Work schedule
6. Information relevant to current FoodShare benefit.

Purpose Or Need for Release of Information (Be Specific)

The purpose for this release of information is for the coordination of benefits between customers who are enrolled in the Reach Dane program and the Wisconsin Shares Agency.

The Wisconsin Shares policy prevents us from disclosing the Wisconsin Shares EBT card number, actual amount of subsidy and the hours approved.

Understandings

This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment or benefits eligibility except for:

- No exceptions
- Exceptions (specify):

The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws.

I may revoke this authorization, in writing, at any time except for information already released as a result of this authorization. The written revocation must be given to the agency / organization I authorized to release information.

Unless revoked, this authorization will remain in effect until the expiration time indicated below.

Choose One:

- Authorization expires as of _____ (Date).
- Authorization expires 12 month(s) from the date I sign this authorization.
- Authorization expires after the following action takes place (specify):

As evidenced by my signature, I hereby authorize disclosure of records to the person(s) or agency(s) specified above.

Person Whose Records Will be Released (Record Subject)

SIGNATURE

Date Signed

Other Person Legally Authorized to Consent to Disclosure

SIGNATURE

Date Signed

Title or Relationship to Record Subject
