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"

reach DANE

reach GREEN

2096 Red Arrow Trail
Madison, WI 53711

Phone: 608-275-6740
Fax: 608-275-6756
www.reachdane.org

APPLICATION FOR ENROLLMENT

Head Start, Early Head Start, & Child Care

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: _____ _____ _____ **Gender**: ☐ Male ☐ Female **Social Security #:**_____-____-_____
mo. day year

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 <u>diagnosed</u> 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 <u>suspected</u> 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)
☐ Center-Based Early Head Start (6 weeks-3 years) *child care subsidy required
☐ Infant/Toddler Child Care (6 weeks-3 years) *private pay or child care subsidy
☐ Home-Based Head Start (3-5years)
☐ Part-Day Head Start (3-5years)
☐ 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 *please check*

☐ Full-Time (35 hrs/wk or more) ☐ Full-Time & Training

☐ Part-Time (under 35 hrs/wk) ☐ Part-Time & Training

☐ Retired or Disabled ☐ Seasonally Employed

☐ Training or School ☐ Unemployed

☐ Unemployed & Training

If Currently Employed, Date Started Job:_____

Employer Name:_____

Gross Income: $_____

Paid (*Check One)*: ☐ Weekly ☐ Every 2 Weeks

☐ Monthly ☐ Other *specify*:_____

If at current job LESS THAN ONE YEAR or UNEMPLOYED list dates of employment for the last 12 months:

Employer:_____

Start Date: _____ **End Date** _____

Employer:_____

Start Date: _____ **End Date** _____

Unemployment Benefits $_____

Per *(check one)*: ☐ **Week** ☐ **2 Weeks** ☐ **Month**

Date Unemployment Benefits Started:_____

Current Employment Status of Secondary Parent/Guardian *please check*

☐ Full-Time (35 hrs/wk or more) ☐ Full-Time & Training

☐ Part-Time (under 35 hrs/wk) ☐ Part-Time & Training

☐ Retired or Disabled ☐ Seasonally Employed

☐ Training or School ☐ Unemployed

☐ Unemployed & Training

If Currently Employed, Date Started Job:_____

Employer Name:_____

Gross Income: $_____

Paid (*Check One)*: ☐ Weekly ☐ Every 2 Weeks

☐ Monthly ☐ Other *specify*:_____

If at current job LESS THAN ONE YEAR or UNEMPLOYED list dates of employment for the last 12 months:

Employer:_____

Start Date: _____ **End Date** _____

Employer:_____

Start Date: _____ **End Date** _____

Unemployment Benefits $_____

Per *(check one)*: ☐ **Week** ☐ **2 Weeks** ☐ **Month**

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 <u>needs</u> of the family/child, <u>not</u> 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

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

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