LCCAA HEAD START/EARLY HEAD START
Enrollment Application
FY 2014-2015

Date of Application: _______________ (mm/dd/yyyy)

Check one that applies:

New Applicant ☐ Sibling Application ☐ EHS Application ☐

Pregnant Mom Applicant ☐ Pregnant Mom of Enrolled Child ☐

Child Demographic Information

1.) Child First Name ______________________________

2.) Child Middle Initial________

3.) Child Last Name ______________________________

4.) Date of Birth ____________________ (mm/dd/yyyy)

5.) Gender: ___ Male ___ Female

6.) Child's Ethnicity:

___ Hispanic or Latino origin (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of their race)

___ Non-Hispanic or Non-Latino origin

7.) Child's Race:

___ American Indian or Alaska Native ___White ___ Asian ___Biracial/Multiracial

___ Black or African American ___ Other ___Native Hawaiian or other Pacific Islander

___ Unspecified

8.) Number of year's child has been enrolled in EHS or HS previously: ________

Child Insurance, Medical and Dental Home Information

1.) Is the child:

___ Enrolled in Medicaid

___ Enrolled in the Child Health Insurance Program

___ Enrolled in combined CHIP/Medicaid Program

___ Enrolled in state-only funded insurance

___ Enrolled in private health insurance

___ Enrolled in other insurance not listed, for example Military Health

___ Child does not have health insurance

2.) Name of Private Insurance Company (if applicable): ______________________________

3.) Primary Insurance Number:______________________________

4.) If child has more than one type of insurance, which is their primary insurance: ______________________

5.) Does the child:

___ Have access to an ongoing source of continuous accessible health care?

___ Receive medical services through the Indian Health Service?

___ Receive medical services through a migrant community health center?

6.) Where does child receive medical care? ______________________________

7.) Medical home address:______________________________

8.) Physician's Name:______________________________

9.) Physician's phone number: (_____) _________________________

10.) Does the child:

___ Have access to continuous, accessible dental care provided by a dentist?
___ Child does not have a dental home

11.) Where does the child receive dental care? ______________________________

12.) Dental Home Address: ______________________________

13.) Dentists Name: ______________________________

14.) Dentists Phone Number: (_____) ______________________

Child Medical Form

1.) Was the child born: ___ More than three weeks early ___ More than three weeks late
___ Child was full term

2.) What was the child's birth weight? (_____) ______________________________

3.) What was the child's length? ______________________________

4.) Did the baby or mother have problems in the hospital? ___Yes ___No

5.) If yes please explain: ______________________________

6.) Have any of the child's direct blood relatives (parents, grandparents, aunts, uncles, brothers, or sisters) had:

Please check all that apply.

___ Bleeding Conditions
___ Allergies
___ Overweight
___ Seizures
___ Tuberculosis
___ Heart Problems
___ Diabetes
___ Sickle Cell Disease
___ Asthma
___ High Blood Pressure
___ Mental Illness
___ Mental Retardation
___ Anemia (low iron)
___ Cancer
___ SIDS
___ Sickle Cell Trait

7.) Other Condition: ______________________________

8.) Has the child ever had any of these conditions? *Please check all that apply.*

___ Allergies
___ Bleeding Conditions
___ Chicken Pox
___ Immune System Disease
___ Mental Retardation
___ Sickle Cell Disease
___ Tonsils Removed
___ Broken Bones
___ Vision Problems
___ High Lead
___ Inherited Disease
___ High Blood Pressure
___ Scarlet Fever
___ Overweight
___ Pneumonia
___ Anemia (low iron)
___ Liver Disease
___ Tubes in ears
___ Diabetes
___ Sickle Cell Trait
___ Measles
___ Cancer
___ Eczema
___ Mumps
___ Hearing Problems
___ Boils
___ Mental Illness
___ Heart Conditions
___ Asthma
___ Hives
___ Rheumatic Fever
___ Underweight
___ Seizures

9.) Other Conditions:______________________________

10.) Did the child require medical treatment for the following chronic health conditions?

___ Allergies
___ Bleeding Conditions
___ Chicken Pox
___ Immune System Disease
___ Mental Retardation
___ Sickle Cell Disease
___ Tonsils Removed
___ Broken Bones
___ Vision Problems
___ High Lead
___ Inherited Disease
___ High Blood Pressure
___ Scarlet Fever
___ Overweight
___ Pneumonia
___ Anemia (low iron)
___ Liver Disease
___ Tubes in ears
___ Diabetes
___ Sickle Cell Trait
___ Measles
___ Cancer
___ Eczema
___ Mumps
___ Hearing Problems
___ Boils
___ Mental Illness
___ Heart Conditions
___ Asthma
___ Hives
___ Rheumatic Fever
___ Underweight
___ Seizures

11.) Did the child receive treatment for any of the following chronic health conditions?

___ Allergies	___ High Lead	___ Tubes in ears	___ Boils
___ Bleeding Conditions	___ Inherited Disease	___ Diabetes	___ Mental Illness
___ Chicken Pox	___ High Blood Pressure	___ Sickle Cell Trait	___ Heart Conditions
___ Immune System Disease	___ Scarlet Fever	___ Measles	___ Asthma
___ Mental Retardation	___ Overweight	___ Cancer	___ Hives
___ Sickle Cell Disease	___ Pneumonia	___ Eczema	___ Rheumatic Fever
___ Tonsils Removed	___ Anemia (low iron)	___ Mumps	___ Underweight
___ Broken Bones	___ Liver Disease	___ Hearing Problems	___ Seizures
___ Vision Problems			

12.) Is this child up-to-date on a schedule of age appropriate preventative and primary health care according to your state's EPSDT schedule for well child care? ___Yes ___No

13.) Is the child currently taking any medication? ___Yes ___No

14.) What is the name of the medication? ______________________________

15.) What is the dosage? ____

16.) Immunization Status: Check which apply

- ___ Child has been determined by a health care professional to be up-to-date on all immunizations appropriate for their age
- ___ Child has been determined by a health care professional to have received all immunizations possible at this time but has not received all immunizations appropriate for their age
- ___ Child is out of compliance regarding immunizations
- ___ Child is exempt from all immunizations

17.) Comments: ____

18.) Has this child received preventative dental care (e.g. cleaning, fluoride treatments, sealant application, etc)?
___Yes ___No

19.) Does the child have a current professional dental exam (less than a year old)? old)? ___Yes ___No

20.) Date of most recent professional dental exam ______________________________________

21.) Has this child been diagnosed as needing dental treatment (e.g. restoration, pulp therapy, extraction, etc.)

___Yes ___No ___No Exam Completed

22.) Has this child received (or are they currently receiving) treatment? __Yes __No __Treatment not required

23.) Why did the child not receive treatment?

- ___NA- not required or child DID receive treatment
- ___ Children left the program before their appointment date
- ___Health insurance doesn't cover dental treatment
- ___ No dental care available in local area
- ___ Appointment is scheduled for a future date
- ___ Medicaid not accepted by dentist
- ___ Dentists in the area do not treat 3-5 year old children
- ___ Other (please specify)____
- ___ Parent did not keep/make appointment

24.) Specify additional reason: ____

____

____

Child Disabilities Form

1.) Does this child have a diagnosed disability? ___Yes ___No ___Suspected

2.) Does this child have an Individualized Education Program (IEP) which indicates that the child is eligible to receive special education/related services by the LEA (Local Education Agency)? ___Yes ___No ___N/A

3.) Has this child received special education and related services? ___Yes ___No ___N/A

4.) Child was diagnosed with primary disability:

___Health Impairment	___Visual impairment, including blindness
___Autism	___Emotional/behavioral disorder
___Traumatic brain injury	___Speech or language impairments
___Learning disabilities	___Hearing impairment, including deafness
___Mental Retardation	___Non-categorical/development delay
___Orthopedic impairment	___Multiple disabilities, including deaf-blind

5.) Child is receiving services for primary disability:

___Health Impairment	___Visual impairment, including blindness
___Autism	___Emotional/behavioral disorder
___Traumatic brain injury	___Learning disabilities
___Speech or language impairments	___Hearing impairment, including deafness
___Mental Retardation	___Non-categorical/development delay
___Orthopedic impairment	___Multiple disabilities, including deaf-blind

Family Demographic

1.) Head of Household: ____

2.) Family type: ___ Two parent/guardian family
___ Single-parent/guardian family (mother-figure only)
___ Single-parent/guardian family (father-figure only)

4.) Is this family homeless? ___Yes ___No

5.) Type of housing:

___ House	___ Hotel/Motel Room	___ Apartment
___ Migrant housing	___ Mobile Home/Trailer	___ Community shelter
___ No housing	___ Other, please specify: ______________________	

6.) Housing Payment arrangement:

___ Own	___ Subsidized Public Housing	___ Rent	___ No payment
___ Exchange Services for Housing	___ Other ______________________		

7.) Does this family receive WIC? ___Yes ___No