Red Cliff Early Childhood Center

PRENATAL APPLICATION

Head Start/Early Head Start is required to use the Department of Health and Human Services HHS Poverty Guidelines to determine income eligibility.

HOW DO I APPLY?

- ✓ **Complete an application along with copies of Parent(s)/Guardian(s) Income.**
- ✓ **After application is received, an application interview will be scheduled and application will be completed.**
- ✓ **Completing the application process does not guarantee enrollment**
- ✓ **Applicants are accepted based upon income (Federal Poverty Level) and prioritized using approved selection criteria**
- ✓ **Upon enrollment to the program, applicants will receive an "Acceptance" letter**

Please Note:

1. **Enrollment is limited, so please complete your application & enrollment appointment immediately for early consideration.**
2. **An incomplete application, including no documentation, will delay the enrollment process. Selection for fall enrollment openings will be released July 15th of each year.**

Policy Council Approval: 3/18/2021
Tribal Council Approval: 3/23/2021

Red Cliff Early Childhood Center
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89830 Tiny Tot Drive (physical)
Bayfield, WI 54814
(715) 779-5030
(715) 779-5046 fax
www.redcliffecc.org

Early Head Start
Pregnant Women/Expectant Families
Application-Intake

Date of Application-Intake: _____

Pregnant Woman Name: _____ Date of Birth: ____/____/____

Address: _____ _____
Street City Zip Code County

Phone: (_____) _____-_____Message Phone: (_____) _____-_____ Tribal Affiliation: _____

Hispanic: Yes ☐ No ☐

Race (check all that apply):

☐ Asian
☐ White
☐ Native American/Alaskan Native
☐ Multi-Racial
☐ Black/African American

Family Receives:
☐ Food Share/SNAP ☐ WIC
☐ Wisconsin Shares (child care)
☐ TANF ☐ General Assistance

Highest Grade/Education Completed:
☐ GED/HSED
☐ HS Graduate
☐ < Grade 9
☐ Grade 10
☐ Grade 11
☐ Associate's Degree
☐ Bachelor's Degree
☐ Master's Degree
☐ Other

Received:
☐ Vocational/trade or ☐ Business school trng.
☐ Skills Training Program
☐ Job Related Training Program

Employment & Training Status:
☐ Full Time ☐ Unemployed
☐ Part Time ☐ Seasonally Employed
☐ Full Time & Trng.
☐ Part Time & Trng.
☐ Retired or Disabled

Member of U.S. Military Active Duty?
Yes ☐ No ☐
Veteran of the U.S. Military?
Yes ☐ No ☐

Spouse or Partner Name: _____ Date of Birth: ____/____/____
Phone: (_____) _____-_____ Tribal Affiliation: _____
Lives with Applicant ☐ Provides Financial Support ☐

Hispanic: Yes ☐ No ☐

Race (check all that apply):

☐ Asian
☐ White
☐ Native American/Alaskan Native
☐ Multi-Racial
☐ Black/African American

Highest Grade/Education Completed:
☐ GED/HSED
☐ HS Graduate
☐ < Grade 9
☐ Grade 10
☐ Grade 11
☐ Associate's Degree
☐ Bachelor's Degree
☐ Master's Degree

Received:
☐ vocational/trade or ☐ business school trng.
Other Programs: ☐
☐ TANF
☐ General Assistance

Employment Status:
☐ Full Time ☐ Unemployed
☐ Part Time ☐ Seasonally Employed
☐ Full Time & Trng.
☐ Part Time & Trng.
☐ Retired or Disabled
☐ Training or School

Member of U.S. Military Active Duty?
Yes ☐ No ☐
Veteran of the U.S. Military?
Yes ☐ No ☐

OTHER FAMILY MEMBERS FINANCIALLY SUPPORTED BY PRIMARY/SECONDARY ADULT (LIVING IN THE HOME)

First & Last Name	D.O.B.	Relationship to applicant

Total # of Children: ____
Total # Adults: ____
Total # in household: ____

PARENT(S)/GUARDIAN(S) INCOME STATUS (Before Taxes)

The following information is required to process this application:
Income Verification: Tax Form or W-2's; Pay Stubs;
Public Assistance: TANF-W-2; and/or SSI-Disability Payments
Other: child support payments, etc.

Applicant	**Spouse**
Employer _____ Employed Since_____	Employer _____ Employed Since_____
☐ Full Time ☐ Part-Time (less than 30 hrs. /week	☐ Full Time ☐ Part-Time (less than 30 hrs. /week
Gross Income $_____	**Gross** Income $_____
Paid: ☐ Weekly ☐ Bi-Wkly ☐ Monthly	Paid: ☐ Weekly ☐ Bi-Wkly ☐ Monthly
W-2 or Tax Return $ _____	W-2 or Tax Return $ _____

OTHER INCOME & CASH ASSISTANCE
(Documents & Verification Required)

Social Security Benefits (monthly)	**SSI** (monthly)	**TANF/W-2** (monthly)	**Child Support** (monthly)	**Foster/Kinship Care** (monthly)	**Unemployment** (weekly)	**Other Income** (List)
$	$	$	$	$	$	$

Family of: _____ Total Income: _____

Family Circumstances (Please check all that apply to you or your **immediate family**)

- ☐ Child Protection Services
- ☐ Foster Care/Kinship Care
- ☐ Death of immediate family member
- ☐ Incarcerated Parent
- ☐ Lack of Prenatal Care
- ☐ High Risk Pregnancy
- ☐ Teen Parent
- ☐ Prenatal Substance Use with current pregnancy
  - ☐ Drugs ☐Alcohol ☐Tobacco
- ☐ Financially affected by COVID (job/day care loss)
- ☐ Disabled Parent
- ☐ Multiple Births (twins, triplets, etc.)
- ☐ Domestic Violence
- ☐ Single Parent
- ☐ Lack of stable Housing or Homelessness
- ☐ First Time Parent
- ☐ Mental Health Concerns (Depression, Anxiety, etc.)
  - ☐ Concern ☐ Diagnosed (Please explain)

Any other concerns you would like us to know about:

_____

__

Please Read Before Signing

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT ALL INCOME IS REPORTED. I UNDERSTAND THAT THE INFORMATION IN THIS APPLICATION WILL BE HELD IN STRICT CONFIDENCE WITHIN THE PROGRAM. I ALSO UNDERSTAND THAT THIS INFORMATION IS BEING GIVEN TO DETERMINE ELIGIBILITY FOR A FEDERAL PROGRAM AND WILL BE VERIFIED FOR ACCURACY.

Signature: _____Date: _____

---***This Section for Agency Use Only***---

Type of Eligibility: ☐ *Income below 100% Poverty Line* ☐ *100-130% Above Poverty Line* ☐ *Public Assistance* ☐ *Homeless* ☐ *Foster Care (applicant)*

Accepted Date: _____ Wait list Date: _____ Wait list Home Visitor: _____

Pregnancy/Health Information

Do you have **regular Prenatal Health Care**: □ No □ Yes

Primary Health Coverage/Insurance: ☐ Badgercare/Medicaid ☐ Private Health Insurance ☐ IHS ☐ None

Last **DENTAL** exam: _____ Clinic/Provider: _____

Prenatal Care Physician (OB-GYN): _____

Date of first Prenatal Care Visit: _____

When did you begin receiving prenatal care: □ 1st Trimester □ 2nd Trimester □ 3rd Trimester

Due Date: _____ (Pregnancy Verification Required)

Is this a high-risk pregnancy: □ Yes □ No **Is this your first pregnancy?** □ Yes □ No

Complications

	Current	Past
Anemia	□	□
Bleeding	□	□
C-Section	□	□
Diabetes	□	□
Fatigue	□	□
Headache	□	□
Hypertension	□	□
Miscarriage	□	□
Neonatal Death	□	□
Pain	□	□
Pre-Term Labor	□	□
Pregnancy Induced hypertension	□	□
Sickle Cell	□	□
Swelling	□	□

Current bed rest or Hospitalization due to _____ How long_____

Previous bed rest or Hospitalization due to _____ How long _____

Do you have any other current health problems or concerns? □ No □ Yes _____

Are you currently enrolled in Zaagichigaazowin Home Visiting Program?

☐ **Yes** ☐ **No**

Do you authorize ECC to share your name and contact number with Zaagichigaazowin Home Visiting Program?

☐ **Yes** ☐ **No**