Council of Three Rivers American Indian Center, Inc.
Intake Office
201 Rochelle Street, Pittsburgh, PA 15210
Telephone: 412-488-2750
Fax: 412-381-5483 or 412-488-7527

Dear Parent/Guardian:

Thank you for your interest in our COTRAIC Early Childhood Education Partner programs. Head Start is primarily a federally-funded program that provides education, health and social services to families with children aged 3, 4 and 5. Head Start programs help children develop academic and social skills that prepare them for school and life. While enrolled in a high quality Head Start preschool program, children receive nutrition, health and supports that help them grow mentally, physically and socially. Families are also offered support to help them obtain services for a variety of needs such as employment or housing.

As parents and families of Head Start children, there are many ways for you to become involved and stay engaged in your children's education and future. Research shows that children whose parents are involved in their education do better in school. Getting involved at the preschool level will prepare you to be active once your children enter elementary school, middle school, and high school. Schools need parent and family involvement to succeed just as much as your children do.

In order to process applications and verify eligibility, the Office of Head Start requires families to provide proof of income and proof of birth. Proof of income may be any of the following:

*W-2's	*income tax returns	*recent pay stub
*child support records	*foster care records	*DPW printout

The goal of partnerships has been to create high quality, seamless services for children and their families. By collaborating with child care providers the needs of enrolled families requiring full day services are met. We are presently working in partnership with the following childcare centers:

~Brightside Academy
~Brookline Sprouts
~Crafton Community Children's Corner
~Future Focus Childcare
~Love, Learn & Play
~Mt. Washington Children's Center
~Thomas Childcare Academy

Kindly spread the word about our Early Childhood Education Partner programs to your friends and neighbors. As our participants, you are our best advocates and recruiters!

COTRAIC also provides high quality educational services for preschool children. All of our classrooms are accredited by NAEYC'S Academy of Early Childhood programs. COTRAIC centers are at the following locations:

Churchview Dorseyville Hazelwood Knoxville

PA pennsylvania
PRE-K COUNTS

HEAD START APPLICATION

Child's Name: _____

Child's Allergies: _____

Child's Medication: _____

Mother/Guardian: _____ DOB: _____

Address: _____

Email Address: _____

Telephone Number: _____ Cell Phone: _____

Father/Guardian: _____ DOB: _____

Address: _____

Email Address: _____

Telephone Number: _____ Cell Phone: _____

School District of Residence: _____

Type of family:
_____ Two Parent Family
_____ Single Parent Family (Mother/Mother Figure Only)
_____ Single Parent Family (Father/Father Figure Only)
_____ Other Family Type: Specify: _____
_____ Foster Family

Are there any court orders regarding custody/visitation/PFA? _____ Yes _____ No
(If you have answered yes, please provide a copy of the court order or PFA. This information **must** be received before your child/children can start the program.)

Do you receive Supplemental Nutritional Assistance Program (SNAP)? _____Yes _____No
Do you receive Women, Infant, and Children (WIC)? _____ Yes _____ No

Has your child ever been enrolled in Head Start or other child development programs?
_____ Yes _____ No

If Yes, specify which program(s) and date(s) of attendance.

_____ Early Head Start from _____ to _____
_____ Head Start from _____ to _____
_____ Greater Hazelwood Family Center from _____ to _____

INITIAL REGISTRATION

1. Child's Name: _____

2. Child's Date of Birth: _____ 3. Child's Gender: _____ Male _____ Female

4. Address: _____

_____ Zip Code _____

5. Home Phone #: _____ 6. Work Phone #: _____
7. Are you currently serving in the United States Military? _____
8. What race/ethnicity do you consider this child? _____
9. What is the family's primary language? _____
   Do you speak/understand the English language? _____ Yes _____ No
10. How many Adults _____ and how many Children _____ in your household?

11. Gives names and birth dates of **all children** in the household:
Child's Name: _____ Date of Birth _____

Child's Name: _____ Date of Birth _____

Child's Name: _____ Date of Birth _____
For additional names, please use other side of this form.

12. Disabilities:	None _____	Suspected:	Diagnosed:	Date
Autism		_____	_____	_____
Emotional/behavioral disorder		_____	_____	_____
Health impairment including deafness		_____	_____	_____
Learning disability		_____	_____	_____
Mental retardation		_____	_____	_____
Orthopedic impairment		_____	_____	_____
Seizures (Epilepsy or Febrile)		_____	_____	_____
Speech or language impairment		_____	_____	_____
Traumatic brain injury		_____	_____	_____
Visual impairment including blindness		_____	_____	_____
Other impairment _____		_____	_____	_____
Family History of Diabetes, High Blood Pressure, etc.		_____	_____	_____

13. Does this child currently receive special services for the above indicated? _____ Yes _____ No
If yes, name and phone number of Provider: _____

Childcare Center applying for: _____

Please tell us how you heard about our program: _____

HEAD START INCOME VERIFICATION

(Certification & Signatures)

Names of Family Members

_____	_____	_____
Adult	Child	Child
_____	_____	_____
Adult	Child	Child

I certify that the information provided in this application, to the Early Childhood Education Program, is accurate and truthful to the best of my knowledge.

_____	_____	_____
Parent/Guardian Signature	Phone Number	Date

AGENCY USE ONLY

This family meets Head Start income eligibility requirements: _____ Yes _____ No Family Size:_____
This family is categorically eligible for Head Start: _____ Yes _____ No Family Size: _____
This family meets Pre-K Counts income eligibility requirements: _____ Yes _____ No Family Size:_____
(Adults/Children)

METHOD OF VERIFICATION

___	Tax Statement	___	W2 Statement	___	Pay Stubs
___	Income Declaration	___	Foster Care	___	Public Assistance Printout
___	Unemployment	___	Income between 100%-130%		
___	Other: Specify _____	___	Homeless	___	SSI

Interview Type:
In Person/Telephone

Head Start/Pre-K Determination

_____ Eligible _____Over Income

USDA Determination

_____ Free _____ Reduced _____ Paid

Income/eligibility certified by:

Signature: _____ Date: _____

Title: _____

HEAD START CONSENT PAGE

Child's Name: _____ Child's Birth Date: _____

CONSENT TO SCREEN:

_____ Heights & Weights _____ Blood Pressure _____ Use of the child's photograph

_____ Vision _____ Speech & Language _____ Hearing (Including Tymps*)

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Please check if your child has had a history of any of the following:
   __Ear Aches __Wax Build-up in the Ears __Frequent Head Colds __Ear Infections

2. Is your child presently on medication for ear problems?
   YES_____ NO_____ If yes, what?_____

3. Does your child have Ear Tubes?
   YES_____ NO_____
   If yes, which ear? Right_____ Left_____

4. When were the tubes put into your child's ears? _____

Tympanometry Hearing Screening: Measures movement of the eardrum which indicates the presence of fluid in the ear.
This consent is valid until **August 31, 2022.** A photocopy of this consent shall be considered valid.

_____

Parent/Guardian Signature Date Relationship to Child

CODE WORD INFORMATION

Code # _____
(OFFICE USE ONLY)

Child's Name: _____ Room #: _____
(OFFICE USE ONLY)

Parent/Guardian Name(s): _____

Address: _____

_____ _____ _____
HOME Phone Number WORK Phone Number OTHER Phone Number

PERMISSION TO TRANSPORT

I hereby give permission for the staff of the Council of Three Rivers American Indian Center, Inc., to provide transportation for _____ in vehicles belong to the agency, staff members or emergency vehicles. The transportation shall include, but not be limited to travel to and from the center, to and from medical and dental appointments, to and from Head Start field trips, and to and from emergency medical and/or dental facilities.

This consent is valid until: **August 31, 2021**

Parent/Guardian Signature: _____ Date: _____

CODE WORD _____

Please give us a code word for your child. Code words and photo identifications are used for the safety of your child. The people who are allowed to pick up your child will need to be listed here and they will need to know the code word and have photo identification. You need to select a word that is easy for you to remember and then share it with the people you have listed. **DO NOT SHARE THE CODE WORD WITH THE CHILD. WE WILL NOT RELEASE YOUR CHILD TO ANYONE WHO IS NOT LISTED BELOW OR DOES NOT KNOW THE CODE WORD. REMEMBER, THE PERSON DROPPING OFF/PICKING UP YOUR CHILD MUST BE 14 YEARS OLD OR OLDER, MUST HAVE PHOTO IDENTIFICATION AND KNOW THE CODE WORD.**

PERSONS PERMITTED TO PICK-UP CHILD **PHOTO ID IS REQUIRED FOR PICK-UP**

Name: _____ Relationship to Child: _____
Legal Name as shown on Identification

_____ _____ _____Home
Phone Number Work Phone Number Address of person picking up child

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Name: _____ Relationship to Child: _____
Legal Name as shown on Identification

_____ _____ _____
Home Phone Number Work Phone Number Address of person picking up child

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