Confederated Tribes of the Umatilla Indian Reservation
Department of Education
Cay-Uma-Wa Head Start Program

46411 Timíne Way, Pendleton, OR 97801
Phone: 541-429-7843
Fax: 541-429-7843

CAY-UMA-WA HEADSTART PROGRAM APPLICATION

CAY-UMA-WA HEAD START APPLICATION

Dear Parent or Guardian,

Thank you for your interest in Cay-Uma-Wa Head Start 2023-2024. Please complete the attached application and return it to the Head Start office as soon as possible**.**

For your application to be considered for selection please include the following documentation:

- ☐ Copy of Child's Birth Certificate
- ☐ Copy of Tribal Enrollment Card or verification the child is a Native American descendant
- ☐ Documentation of Disability (if applicable)
- ☐ Income Verification or proof of public assistance as claimed on page 2 of this application (Check stubs, previous year's Federal Tax return, documents with public assistance case numbers, etc.)
- ☐ Child & Adult Care Food Program CHILD ENROLLMENT FORM
- ☐ Child History Form & Child Social & Developmental History Forms (2 forms)

In addition to the above, all children will need the following health information on **file within 45 days of the first day of school (November 2023 deadline): or 45 days of your initial enrollment date.**

- ☐ Well-child exam or Physical within the past 12 months
- ☐ Dental exam within the past 12 months
- ☐ Nutritional Assessment within the past 12 months (from your WIC office)
- ☐ Immunization Status (must be up-to-date or have all immunizations possible at time of enrollment)
- ☐ Blood level lead screen
- ☐ Blood iron level screen (hematocrit or hemoglobin)

Please take time to make appointments as soon as possible to ensure availability of appointments before school begins in September. E **Mail or submit completed applications** (turn in pages 3-9, keep this page for reference of documents still needed) **and documentation** to the **Head Start office** located in the **CayUmaWa Education Center.**

Mailing Address:
CTUIR Cay-Uma-Wa Head Start
46411 Timíne Way
Pendleton, OR 97801
Telephone 541-429-7843
Email: mickifabian@ctuir.org

Head Start staff are available to answer questions and assist you as needed to complete your child's application. Our office hours are 7:30 AM to 4:00 PM Monday through Friday. We look forward to meeting you and your child soon!

CAY-UMA-WA HEAD START APPLICATION

Has the applying child been enrolled in Early Head Start/Head Start program other than Cay-Uma-Wa?

☐ Yes ☐ No

If yes, where? _____
Program Name Address City State Zip Phone Number

Applying Child's Name: _____
First Middle Initial Last

Gender: ☐ Male ☐ Female **Date of Birth:** _____

Home Address: _____
Street Address (Not PO Box#) City State Zip Code Phone Number

Mailing Address: _____
(Only if different than the home address)

Race:

☐ African American
☐ Caucasian
☐ Hispanic
☐ Asian
☐ Other
☐ Native American – Tribe & Enrollment Number: _____
Native American Descendent: ☐ Yes ☐ No

Do you have any concerns about your child's overall health or development (speech, hearing, vision, etc.)**?**

☐ Yes ☐ No
If yes, please describe your concerns:
_____

Is this child currently receiving special education services?

☐Yes ☐ No

Insurance Information – *please check all that apply*

a. ☐ Indian Health Service
b. ☐ Oregon Health Plan (Medicaid)
c. ☐ Children's Health Insurance
d. ☐ Private Insurance: _____
Name of Insurance Group Number
e. ☐ No Insurance

Family Composition

Please read the list and check the box that best describes your family:

☐ Two parent family
☐ Foster Family
☐ Single parent family (father figure only)
☐ Single parent family (father figure only living with partner)
☐ Single parent family (mother figure only)
☐ Single parent family (mother figure only living with partner)
☐ Other relative(s), specify: _____
☐ Other family type, specify: _____

CAY-UMA-WA HEAD START APPLICATION

Household Composition

(All persons living in the household who are supported by the income of the child's parents or guardians and related to the parents or guardians by blood, marriage or adoption.)

Name	Date of Birth	Relationship to the child (mother, father, sibling, aunt, uncle, friend, grandparent, step parent)	Race: Native American *(enrollment number & tribe),* African American, Hispanic, Caucasian, Asian other	Highest Level of Education or Current Education Status, if in school	Completed
Example: Sarah Jane	*02/27/1999*	*Aunt*	*Umatilla, X-1234*	*BMCC*	*Currently Attending*
Example: John Doe	*05/15/1992*	*Father*	*Caucasian*	*Diploma/GED*	*Complete 2011*

Total Adults in Household =_____ Total Children in Household =_____

Income Information

(Please include **all** of the income information that applies for the applying Head Start child's parents or legal guardians or family members who reside within the household that are receiving SSI and **are supported by the parent or guardians income**. In the event of joint custody of a child and neither parent provides child support to the other, the income for both parents must be provided). (***Half of the total income for each parent will be combined to determine income eligibility***).

Please check all that apply per person:

Who	Employment Retirement	Child Support	Military	Veteran Benefits	SSI	Public Assistance -cash -food stamps -TANF	Unemployment Compensation	Dividends
Example: self, Jane/John doe, etc.	✓					✓	✓	

Many families receive services or financial assistance from one or more programs or agencies. Does your family receive any of the following types of services or financial assistance?

Check all that Apply:

☐ Public Assistance/Welfare (TANF) (SNAP/FOOD STAMPS)

☐ Supplemental Security Income (SSI)

☐ Other, specify:

☐ _____

☐ None of the above

If the family is receiving public assistance, when did you start to receive benefits: _____

Is the applying child in foster care? ☐ Yes ☐ No

Do you consider yourself homeless? ☐ Yes ☐ No

If yes, please explain: _____

CAY-UMA-WA HEAD START APPLICATION

Contact Information

First Biological Parent or Guardian Name:

First Middle Initial Last

Mailing Address:

☐ Same as Child Street /Apt # City State Zip Code

Phone Numbers:

Home Work Cell Message

Email Address: _____ or _____

Does this person live with the Child? ☐ Full time ☐ Part time ☐ Not at all

Second Biological Parent or Guardian Name:

First Middle Initial Last

Mailing Address:

☐ Same as Child Street /Apt # City State Zip Code

Phone Numbers:

Home Work Cell Message

Email Address: _____ or _____

Does this person live with the Child? ☐ Full time ☐ Part time ☐ Not at all

Copies of the following:

☐ Birth Certificate
☐ Tribal enrollment card or a copy of the child's direct descendant's enrollment information.
☐ Income verification for each person as claimed on page 2 of application. (Please attach a copy of records to demonstrate income claimed-can use tax forms, employment stubs, TANF reports, etc.).
☐ Well-child exam including updated immunizations, nutritional and dental exams within the past year; at least one each lead and iron blood level screens.

Please be sure to set up a "Head Start Physical" appointment with Yellowhawk Clinic or your child's regular pediatrician as soon as possible. Head Start physicals ***must include medical, dental, Nutritional Assessment, and immunizations, before the first day of school.

By signing this application, you are certifying that all information provided is accurate and truthful to the best of your knowledge. This information will remain ***confidential***.

Signature: _____ Date: _____

Relationship to the Child: _____ Preferred Contact Method: ☐ Email ☐ Phone ☐ Other

CAY-UMA-WA HEAD START APPLICATION

****THIS SECITON TO BE COMPLETED BY HEAD START STAFF****

For Head Start Office

☐ Completed Application

To be completed before the 1st day of school:

☐ Well Child Check-Up
☐ Dental Records
☐ Immunizations
☐ Nutrition Assessment| WIC Screening

Attachments:

☐ Birth Certificate
☐ Enrollment
☐ Income

Information still needed:

☐ Birth Certificate Date: _____
☐ Enrollment Date: _____
☐ Income Date: _____

☐ Well Child Check-Up Date: _____
☐ Dental Records Date: _____
☐ Immunizations Date: _____
☐ Nutrition Assessment| WIC Screening Date: _____

Date Stamped Received: _____ **Received by:** _____

CAY-UMA-WA HEAD START APPLICATION

AUTHORIZATION TO RELEASE INFORMATION

In order to best help your child, it is sometimes necessary to obtain information from other agencies that have worked with you and your child as well as provide information to them about your most current information and/or situation. By signing this form, you are giving permission for the agencies named below to share information. We will only request information needed to serve your child and family in the Head Start setting. As with all personal family information, the information we receive will be kept (filed) in a ***confidential*** manner that meets the Performance Standards 1303.21. This agreement shall be good for one year.

Child's Name: _____

Additional Children's names: _____

Print Name of Person Signing Release: _____

Please Initial next to each agency with permission to share information:

_____ Yellowhawk Tribal Health Center

_____ Pendleton Pediatric Specialists of Pendleton

_____ Inter Mountain Education Service Department

_____ CTUIR Enrollment Officer

_____ CTUIR Daycare

_____ Other Childcare Center or Provider: _____

_____ CTUIR Children & Family Services Department

_____ Others Listed: _____

_____ Others Listed: _____

The above listed agencies have my permission to release information about the above child to Cay-Uma-Wa Head Start as needed for provision of Head Start services as well as Cay-Uma-Wa Head Start to release information to the listed agencies.

_____ _____

Signature of Parent/Guardian Date Signed

CAY-UMA-WA HEAD START APPLICATION

PARENTAL PERMISSION FORM

By signing this form I give permission for my child, _____ to participate in the following activities while enrolled in the Cay-Uma-Wa Head Start Program. I understand that my permission is voluntary and can be revoked at any time. I understand that I will receive written results of all screens.

Please Initial:

_____ Hearing Screen

_____ Vision Screen

_____ Fluoride Varnish

_____ Dental Screen

_____ Dial-3 Screen

_____ Weight and Measured

_____ I give permission for my child to be photographed while participating in Cay-Uma-Wa Head Start activities for the CUJ, parent newsletters and/or other publications.

_____ In the event of life-threatening emergencies, I give permission for Cay-Uma-Wa Head Start to seek emergency medical care for my child. Cay-Uma-Wa Head Start will use the Tribal Emergency Response system. The parent/guardian of the child will be contacted as soon as possible. If not available, the program will attempt to contact the persons whom you have listed as emergency contacts in your child's file.

_____ I give permission for my child to participate in local field trips (walks around the Tribal Campus and up to Tamastslikt) and in prearranged field trips (off Tribal Campus).

_____ I give permission for my child to be videotaped or photographed during activities in the while attending Cay-Uma-Wa Head Start. The videotapes and pictures are sometimes used for instructional purposes in trainings, presentations, reports, or for our publications (newsletters, brochures, calendars,). All tapes and pictures used are presented with respect for the children who are in the episode.

_____ _____

Signature of Parent/Guardian Date Signed

_____ _____

Signature Witness Date Signed

File Number: _____

CAY-UMA-WA HEAD START APPLICATION

CAY-UMA-WA HEAD START NUTRITION ASSESSMENT RECORD

Child's Name: _____ DOB: _____ Classroom: _____

Assessment Date: _____		
Length or Height/Age: _____	_____ inches _____**%ile**	_____ inches _____**%ile**
Weight/Age: _____	____ lbs ____ oz _____**%ile**	____ lbs ____ oz _____**%ile**
Wt/Length or BMI: _____	_____ **%ile**	_____ **%ile**
Hgb/Hct: _____ (Most recent)	Date/Measurement _____ /_____	Date/Measurement _____ /_____

☐ **WIC Participant** ☐ **Not WIC Participant** ☐ **Referred to RD**

Due for Recert: _____ Due for Follow-Up: _____

Goal: _____

_____

Comments: _____

_____

WIC Staff: _____ Date: _____

☐ **WIC Participant** ☐ **Not WIC Participant** ☐ **Referred to RD**

Due for Recert: _____ Due for Follow-Up: _____

Goal: _____

_____

Comments: _____

_____

WIC Staff: _____ Date: _____

For Data Entry Person Only:

Nutrition Assessment:
P = Nutrition Assessment Complete
N = Not on WIC

Growth Assessment:
F = BMI ≤ 10th or ≥ 95th
Hgb: F = 9-23 months < 11.0 and 2-5 yrs <11.1

Health & Mental Health Services Coordinator: **Must view graph for BMI to get %ile**.