

Osage Nation Head Start

This is a **RECRUITMENT** application only. **This does not guarantee your child's acceptance.** The children are accepted by guidelines established by our Parent Policy Council and by the Office of Head Start Federally Mandated Guidelines. **We serve families throughout Osage County area in a manner that does not discriminate on the basis of race, color, national origin, sex, religion, age or disabilities.**

I have read and understand the above statement.

Child's Name: _____

Parent's Signature

Date

Ages of other children in the home: _____

Detach and give bottom portion to parent.

The following information checked is needed before your child's application will be considered for acceptance.

_____ **Income Verification** (*Pay Stub, W- 2, Income Tax, Letter from Employer, TANF, Unemployment, SSI, Foster Care Reimbursement, Doc.of No Income*)

_____ **Immunization Record**

The following information checked is needed to complete your child's file;

_____ Child or Parent's Proof of Indian (if applicable)

_____ Birth Certificate

_____ IHS Clinic _____ Chart # _____

_____ Social Security Numbers

If your child is accepted into the program, it is **mandatory that they have a physical and dental exam.** This information needs to be provided as soon as possible to be considered for enrollment. You may contact your local center for more information or call the main office located in Pawhuska, 1-800-287-6647 or 287-5460.

Center's Phone Number: _____

ONHS 02/2010

Sklatook 918-699-5471
Fairfax 918- 642-5505
Hominy 918-699-5648
**Recruitment Application Only

OSAGE NATION HEAD START
P.O. BOX 1389
PAWHUSKA, OK. 74056
1-800-287-6647 FAX: 1-918-287-3416

McCord/Shidler 580-762-0412
Pawhuska 918-287-5464
Barnsdall 918-699-5561

Center: _____ Child's Sex Male Female Date of Application: _____

Mother's SSN _____ Father's SSN _____ Child's SSN _____

Child's Last Name _____ First Name _____ Middle _____ Date of Birth _____

Street Address (Use Pencil) _____ City _____ State _____ Zip Code _____

Mailing Address (Use Pencil) _____ City _____ State _____ Zip Code _____

() _____ () _____ () _____ () _____ Email Address: _____
Home Phone (Pencil) Message Phone (Pencil) Cell Phone (Pencil) Work Phone (Pencil)

Fathers Name _____ Ethnic Code(Circle all that apply) Primary Language _____
B= Black H= Hispanic E= English
A= Asian W= White S= Spanish
N= Native American O= Other _____
Tribe: _____ Degree of Blood: _____

Mothers Name _____ # of Adults in Family _____ #of Children in Family _____

Guardians Name _____

Family Type: (Circle One) Two Parent Single Parent Relative Foster Homeless Other

TANF Case # _____ Sooner Care # _____ Private Insurance Name and # _____

Medication: _____ Allergies Bites: _____ Food: (Need a Dr's statement) _____

Has your child been diagnosed for special need services? Yes No ***If yes, please provide documentation
Please Specify: _____ By Whom: _____

Has your child previously been enrolled in another Head Start Program or Child Development Program? yes
no if so, where: _____

In order to help us plan for your child we need to know if they are Potty Trained : yes no
(THIS WILL NOT AFFECT THEIR ACCEPTANCE)

A copy of the following information must be attached before the application will be considered complete and screened: Income Verification; Immunization Record; Certificate of Degree of Indian Blood Card (CDIB) on child and/ or parent; Child's Social Security Card; Child's Birth Certificate.

Upon acceptance for enrollment, your child will need a completed physical, dental, and updated immunization record.

I certify that the attached information is true and accurate to the best of my knowledge. I also understand that all information is kept confidential.

Applicant Signature/ Date _____

Receiving Staff Signature/ Date _____



Head Start Criteria of Needs System for ERSEA

Child's Name: _____ **Date:** _____ **Total:** _____

- _____ 1. Immediate family member with documented diagnosed disability.
- _____ 2. Court ordered enrollment or referred from another agency.
- _____ 3. Substance abuse or domestic violence in the home.
- _____ 4. Single-parent family
- _____ 5. Crisis in the family during the past 12 months, includes, but is not limited to; fire, death, incarceration, life-threatening illness, etc.
- _____ 6. Child was enrolled and participated in a Head Start program last year including home base, and/or Early Head Start or other agency.
- _____ 7. Family is receiving TANF benefits.
- _____ 8. Non-English speaking and/or literacy needs within the family.
- _____ 9. Child being raised by persons other than parent/s, includes foster situations.
- _____ 10. Child suspected of or diagnosed as having a disability.
- _____ 11. Child has had little or no opportunity to interact with children close to his or her own age.
- _____ 12. Pregnant woman.
- _____ 13. Parent is under the age of 18.
- _____ 14. Child's parent/s are working or are full time students.
- _____ 15. Family is residing in the home of other family members or friends.
- _____ 16. None of the above apply.
- _____ 17. OTHER (Describe) _____

**** OFFICE USE ONLY ****

Age: 3 yr. 4yr. Under Age Number in Family _____ CNP: _____
Sex: Female Male Under Income: _____ Over Income: _____
Ethnic Code : _____ Disability: Yes No
Homeless: _____ TANF: _____ Foster Child: _____
Complete Application: _____ Incomplete Application: _____ (specify: _____)
Replacement for Drop: Yes No Date of Acceptance: _____
Screener: _____ Date: _____