

Early Childhood Programs

Provided through Lincoln Public Schools E^XCITE
and Lincoln Action Program, Inc.



Dear Applicant:

The Early Childhood Programs provided through Lincoln Action Program, Inc. (Head Start) and Lincoln Public Schools (E^XCITE) offer a wide variety of services. The services are designed to support children and families across the community. **Parent participation is important in all program options.**

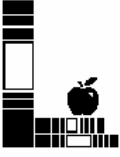
To apply, please bring your application along with the following 4 documents to the Federal Programs Office, 5901 "O" Street, Lincoln, NE 68510:

1. **Birth verification by:**
 - a) **certified copy of child's birth certificate**
 - b) **other proof of child's identity and age**
(i.e., official birth records or passport) **accompanied by an affidavit explaining inability to produce the birth certificate**
2. **Income verification for the past year. [We prefer a 2006 tax return or W-2s or check stub from TANF payment]**
3. **Child's immunization record**
4. **Social Security card (if available)**

Thank you for completing the application. We look forward to working with your family. If you have questions, please contact Lincoln Public Schools, 5901 "O" Street, 402-436-1995, or Lincoln Action Program, 210 "O" Street, 402-471-4515.

The Selection Committee

<u>Interpretation services available</u>		
Arabic—436-1958	Russian—436-1942	Spanish—436-1938 or 436-1867
Sudanese—436-1956	Vietnamese—436-1939	Kurdish/Farsi/Pashto—436-1894
Croatian—436-1986	Bosnian—436-1986	Serbian—436-1986



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Referred by: _____

CHILD INFORMATION: (Please Press Hard)

Child's First Name:		Last Name:	
Preferred Name:		Child's Social Security #	
Date of Birth:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <i>Tribal Affiliation:</i>			
Primary Language:		Do you speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Do you need a translator? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does child receive Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicaid # Plan	
Other Health Insurance?		Dental?	

FAMILY INFORMATION:

Parent/Guardian Names:		
Address		Zip Code
Phone: Home/Message:		Work Phone:
Child: lives with: <input type="checkbox"/> One parent <input type="checkbox"/> Two parents <input type="checkbox"/> Foster parent <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other <i>Who?</i>		
Number in Family:	Number of children:	Number in household:
Best time to contact parent: <input type="checkbox"/> Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends		
Do you receive TANF (AFDC)? <input type="checkbox"/> Yes <input type="checkbox"/> No Caseworker's Name:		
Do you receive Title XX or state funds to pay for child care? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, # of hours: _____ Caseworker's Name:		
Is your child in child care? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what days and hours does your child attend? _____		
Child care center/provider name:		
Would you consider changing child care centers to receive HeadStart services? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Which program option would you prefer? <input type="checkbox"/> Home Base <input type="checkbox"/> Center Base <input type="checkbox"/> Full Day		

TRANSPORTATION INFORMATION:

How will your child get to the program? <input type="checkbox"/> Parent <input type="checkbox"/> Bus <input type="checkbox"/> Other		
Are you able to transport your child? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If by bus, what is the Pick-up Location:		

EMERGENCY INFORMATION:

Emergency Contacts:

Name	Address	Phone	Relationship to child
1.			
2.			
3.			

Child's Name:

Family Member Information:

Please list all adults living in household

First and Last Name	Date of Birth	Soc.Sec.#	Sex	Last Grade Completed	Working part time, full time, or un-employed?	How related to child?
			M F			
			M F			
			M F			

Please list all children in household

First and Last Name	Date of Birth	Soc.Sec.#	Sex	If attending school, what grade?	How related to child:
			M F		
			M F		
			M F		
			M F		
			M F		
			M F		
			M F		

<p>The following information helps the program better understand the needs of your family. All information is confidential and not shared outside of Lincoln Action Program or Lincoln Public Schools.</p>	YES	NO
<p>Do you have a concern about your child's development? If yes, describe your concern _____</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Has your child (applicant) been through Lincoln Public Schools Early Childhood Special Education evaluation?</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Did your child qualify for Early Childhood Special Education Services?</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Is your child currently receiving Early Childhood services?</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Was your child born more than three weeks early? Birth weight: _____ lb. _____ oz.</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Has your child (applicant) had two or more ear infections the past year?</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Has your child (applicant) ever been hospitalized or had surgery? For what? _____ When? _____</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Has your child (applicant) ever had a serious accident that resulted in one of the following: <input type="checkbox"/> Broken bones <input type="checkbox"/> Head injury <input type="checkbox"/> Burn (please describe) <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Poisoning <input type="checkbox"/> Fall</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Does your child (applicant) have one of the following: <input type="checkbox"/> Asthma <input type="checkbox"/> Heart Problems <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Diabetes <input type="checkbox"/> Weight Problems <input type="checkbox"/> Cancer <input type="checkbox"/> Epilepsy or Seizures <input type="checkbox"/> Vision <input type="checkbox"/> Other</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Does your child take medication on a regular basis? If yes, for what: _____</p>	<input type="checkbox"/>	<input type="checkbox"/>
- 3 -	YES	NO

CHILD'S NAME		
Have you or a family member identified a need or been involved in counseling in any of the following areas: (Please check) <input type="checkbox"/> Child Abuse/Neglect <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Alcohol/Drug Issues <input type="checkbox"/> Anger Control <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Parenting Needs <input type="checkbox"/> Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Has your family had an open case with Child Protective Services in the past three years?	<input type="checkbox"/>	<input type="checkbox"/>
Is there an immediate family member currently incarcerated or involved with the legal system? (i.e., probation)	<input type="checkbox"/>	<input type="checkbox"/>
Does any adult in your immediate family need basic reading, writing, and/or math skills?	<input type="checkbox"/>	<input type="checkbox"/>
Does either parent need to complete their high school education?	<input type="checkbox"/>	<input type="checkbox"/>
Is either parent attending vocational training/post high school/college? What _____ Where _____	<input type="checkbox"/>	<input type="checkbox"/>
Does either parent need to learn to speak English?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an immediate family member with a life threatening disease or serious chronic illness? (ex. cancer, diabetes, tuberculosis)	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an immediate family member with a mental or emotional disability?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been divorced or separated from your spouse or significant other within the last year?	<input type="checkbox"/>	<input type="checkbox"/>
Has there been a death in the immediate family within the last 2 years? If yes, how was this person related to the child?	<input type="checkbox"/>	<input type="checkbox"/>
Has there ever been a child who died in the immediate family?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dependable transportation? Do you use: <input type="checkbox"/> city bus <input type="checkbox"/> taxi <input type="checkbox"/> own car <input type="checkbox"/> relative/friend	<input type="checkbox"/>	<input type="checkbox"/>
Have you been homeless in the last year?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a refugee in the last 5 years? If so, from where? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does your family have enough food to meet your daily needs?	<input type="checkbox"/>	<input type="checkbox"/>
Is anyone in your immediate family on active duty with in the military?	<input type="checkbox"/>	<input type="checkbox"/>
If there is anything else you would like to tell us about your family, please write your comments here.		

CERTIFICATION: I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence with the agency and will be accessible to me during business hours.

PARENT SIGNATURE × _____ **DATE** _____