



Prenatal y menores de 3 años

Early Head Start es un programa basado en la familia que ofrece apoyo en las áreas de desarrollo de la niñez, educación a padres, servicios sociales y de salud para: mujeres embarazadas, infantes, niños menores de 3 años y sus familias. El programa de Early Head Start ofrece dos (2) opciones: basado en el hogar y basado en el centro de cuidado. La opción basada en el hogar ofrece servicios a través de un Consejero(a) Familiar que les visita por una hora y media en sus hogares. El programa en los centros de cuidado provee servicios en unos de los centros de Early Head Start así como a través de visitas en su hogar dos veces al mes. **Los honorarios del centro de cuidado son la responsabilidad de las familias y pueden estar cubiertas por un subsidio estatal (Título XX) si usted califica.** También, ofrece oportunidades de participar en reuniones familiares sociales. Llame al Lincoln Action Program, (402) 471-4515, con consultas y preguntas.

Daremos preferencia de inscripción a familias que cumplen los requisitos de ingresos y tienen niños menores de tres años o están embarazadas. Los niños pueden estar en el programa hasta la edad de tres años. Por favor, complete la aplicación e incluya copias de la siguiente información.

1. La verificación de ingresos:

(Incluye todos los ingresos recibidos en el año pasado, por ejemplo, sueldo antes de deducciones, sustento mensual de niños, beneficios de colecta por desempleo, beneficios por veterano, beneficios de asistencia pública, pensiones, becas, ingresos de alquiler)

- ❖ Preferiblemente la declaración de impuestos del año pasado
- ❖ Posiblemente otras formas de declaración serán aceptadas. Por favor, pida más información. Una carta firmada por un trabajador(a) social que verifique la asistencia del Estado (Proveemos la carta).

2. El acta de nacimiento puede ser cualquiera de las siguientes:

- ❖ Copia del hospital
- ❖ Copia oficial del "Bureau of Vital Statistics" (ubicada en el tercer piso del the State Office Building, Calles 14th y L)

***El acta de nacimiento es requerido dentro 45 días de ser aceptado en el programa. Apreciamos una copia cuando entregue la aplicación si la tiene.**

La aplicación no está completa y no podemos considerar al niño(a) para inscripción hasta que tengamos la verificación de ingresos.

**Entregue o mande aplicaciones completas: Lincoln Action Program
Early Head Start
210 O Street
Lincoln, NE 68508
(402) 471-4515**

Si usted necesita ayuda para completar la aplicación y desea hablar con un intérprete, por favor llame al:

**EARLY HEAD START
Lincoln Action Program
210 O Street
Lincoln, NE 68508
(402) 471-4515**

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Child/unborn information

Child's First Name: _____ Last Name: _____
Preferred Name: _____ Child's Social Security # _____
Date of birth: _____ Race: _____ Language: _____ Sex: M F
Does this child/pregnant woman receive Medicaid? Y N
Medicaid # _____ Plan _____
Other Health Insurance _____ Dental _____
Referred by: _____

Family Information

Child lives with One parent Two parents Foster parent Other (Circle all that apply)
Are you pregnant? Yes ___ No ___ When is your due date? _____
Number in Family: _____ Number in Household: _____ Number of Children: _____
Parent/Guardian Name: _____
Address: _____ Zip Code _____
Home Phone/Message: _____ Work Phone: _____
Best Time to Contact: Mornings Afternoons Evenings Weekends

Do you receive TANF (AFDC)? Yes ___ No ___ Worker's Name _____
Does your child currently attend child care? Yes ___ No ___ If yes, where? _____
Do you receive state funding to pay for your child care (Title XX)? Yes ___ No ___
Would you consider changing your childcare provider to receive EHS center based services?

Emergency Contacts:

Name	Address	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Tell us why you would like to be a part of the Early Head Start program.

EARLY HEAD START

Child's Name

Date of Birth

Family Member Information:

Please list all adults living in household

First & Last Name List parent(s) first	Date of Birth	Social Security Number	Sex	Last Grade Completed	Work FT	Work PT

List all children in household

First and Last Name of Child Applicant first	Date of Birth	Social Security Number	Sex
			M F
			M F
			M F
			M F
			M F
			M F
			M F

INCOME: Please list your family income for the past year (proof of income required)

Family Member	Amount per year	Source of Income

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

Lincoln Action Program's Early Head Start partners with the following agencies: CEDARS, Lincoln/Lancaster County Health Department, UNL Psychological Consultation Center, and UNL cooperative Extension Service, to provide comprehensive services. By signing below, I authorize Early Head Start staff to give and receive information contained in this application with Program partners for the following purposes: provide information for referrals/services for programs I may be eligible for, and demographic information to be used for statistical purposes.

Signature _____ Date _____

NAME	YES	NO
Are you interested in having your child in a Quality EHS Childcare Center?		
Do you have transportation? City bus taxi own car relative/friend		
Is a parent currently deployed on active duty with the military?		
Is either parent attending school or a training program?		
Does either parent need basic reading, writing, and/or math skills?		
Does either parent need their GED?		
Does your family have enough food to eat?		
Does any adult in your immediate family speak English?		
Are you pregnant now?____ If so, are you seeing a doctor regularly?____ Does the pregnant woman have a history of or currently have any of the following conditions? Smoking__ Drug/Alcohol abuse__ Preterm labor__ Preterm delivery__ High Blood Pressure__ Diabetes__ High risk____ Miscarriage_____		
Was your child born early? How many weeks? Infant birth weight?		
During the pregnancy with this child did mom have any of the following? Smoking ___ Drug/alcohol use__ Preterm labor__ High blood pressure__ Fetal distress__ Placental Abruption__ Multiple birth__ Domestic Violence__ Other risk factors_____	___	___
Does your child (applicant) have one of the following conditions? Asthma__ Cancer__ Diabetes__ Kidney problems__ Heart problems__ Epilepsy/Seizures_ Vision problems__ Hearing problems__ Weight problem__ Ear infections__ Other_____		
Has your child (applicant) ever been hospitalized or had surgery? For what?_____ When?_____		
Do you, or anyone else, have concerns about your child's development? Who?_____ What concern?_____		
Has this child received an evaluation because of concerns about development?		
Is this child receiving Early Childhood Intervention Services/Special Education?		
Has your child been diagnosed with a disability by a health professional? Who?_____ Can we contact them? yes__ no_____		
Do you have an immediate family member with a physical disability?		
Do you have an immediate family member with a mental or emotional disability?		
Do you have an immediate family member with a life threatening disease or chronic illness?		
Has there been a death in the immediate family within the last two years?		
Have you been divorced or separated from your spouse or significant other within the last year?		
Have you been homeless within the last year?		
Have you been a refugee within the last 5 years?		
Has anyone in your family experienced the following? Sexual Abuse____ Alcohol/Drug Issues__ Anger Control__ Domestic Violence__ Parenting Issues__ Child Abuse/neglect__ Other_____		
Have you, or a family member, been involved in counseling in the past year?		
Do you desire counseling?		
Has your family been involved with Child Protective Services in the last 3 years?		
Is there an immediate family member currently incarcerated or involved with the legal system in the last three years? (i.e. jail or probation)		
Have you or anyone else identified a need for additional parenting support?		