Keep this sheet for your records!

******PLEASE READ THIS BEFORE YOU TURN IN YOUR APPLICATION! *****

Thank you for taking the time to consider the Grand Traverse Band Early Head Start Home Based Program for yourself. Here are a few things that you will need to know…

After completing and returning this application, a Selection Criteria form will be filled out, and you will be assigned "points" based on your eligibility for the program. You will be accepted based on these points. Eligibility factors include (but are not limited to): Income Eligibility (the Federally established Poverty Guidelines are used to make this determination), Special Needs of pregnant mother, Need for Services, Parental Status, and other factors. While GTB Members are given priority when income eligibility factors are met, this program is open to all individuals regardless of Tribal Affiliation.

When all openings are filled, a waiting list will be established. Expectant mothers on the waiting list will be chosen to fill vacancies based on the points they receive from the Selection Criteria, regardless of when the application was turned in. It is not possible to tell expectant mothers where they placed on the waiting list, due to the changing nature of applications received.

Please be sure to submit your Income Verification WITH THIS APPLICATION. Please submit your 1040 tax return or your W2's from 2019. If you did not file taxes, please submit income verification for the past 12 months which would include: Wages/Salary, Unemployment Compensation, PerCapita Payments, Other Trust Money Payments, Child Support Payments, SSI Payments.

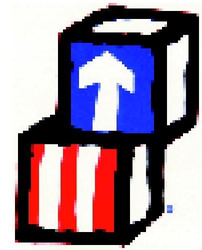
If you need assistance completing this application, or have questions, please contact Leona at (231) 534-7929 or one of our Home Visitors at (231) 534-7280

If you are accepted for enrollment, you will be required to submit the following information:

- Your Insurance information
- Your Tribal ID (if applicable)

Thank-you again for considering The Grand Traverse Band Early Head Start Home Based Program.

Grand Traverse Band
Early Head Start, Head Start & GSRP
Enrollment Application
2020-2021



2605 NW Bay Shore Drive
Peshawbestown, MI 49682
Phone: (231)534-7650 FAX (231)534-7583

Please indicate which program you are applying for: ☐**Head Start/GSRP** ☐**Center-Based Early Head Start** ☐**Home-Based Early Head Start**

Applicant Information: (Child or Expectant Woman)

First Name	Middle Name	Last Name	Date of Birth:	Gender: ☐Male ☐Female

Address where applicant/child resides:
Street:
City: State: Zip Code:
County:

Mailing Address:
Street/PO Box:
City: State: Zip Code:
School District:

What is the Applicant's Race:
☐American Indian/Alaskan Native
☐White
☐Black/African American
☐Bi-racial/multi-racial
☐Asian
☐Native Hawaiian or other Pacific Islander
☐Other:______________

What is the Applicant's Ethnicity:
☐Hispanic or Latino origin
☐Non-Hispanic or Non-Latino Origin

Is Applicant a:
☐GTB Member
☐Member of another Tribe: _____
☐Not Affiliated with any Tribe

Language(s) spoken in the child's home?
Primary:________________
Secondary:________________

Is Applicant Currently:
☐Enrolled in Head Start
☐Enrolled in Early Head Start
☐Home Based
☐Not Previously Enrolled in Head Start or Early Head Start

Applicant's Custodial Information:
☐Does not apply in my situation
☐Sole Custody
☐Joint Custody—both biological parents
☐Joint Custody—other; Explain:________________________________
☐Physical Custody: Explain who has legal custody:__________________
☐Foster Care (Please explain and provide a copy with your application)
Caseworker:____________________
Phone:________________________

Is there a protection or restraining order regarding the child?
☐No ☐Yes (Please explain and provide a copy with your application)

Are there special visitation orders we should be aware of?
☐No ☐Yes (Please explain and provide a copy with your application)

Household Composition: List the Primary Caregivers

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Other:____________________

Primary Adult **Lives with Child:** ☐ **Yes** ☐**No**

First Name: Last Name:
Date of Birth: Relationship To Child:
Is Parent/Guardian a: ☐GTB Member
☐Member of Another Tribe________________
Telephone Number/Contact Information:
Home:__________________ Work:________________
Cell Phone:_______________ Message:________________
E-Mail Address: ________________________________

Are you employed:
☐Part time ☐Full Time ☐Seasonally ☐US Military-Active Duty
☐Retired ☐Unemployed ☐Self Employed ☐Disabled
Employer Name:________________________________
Are you attending school/job training:
☐Yes ☐No
Highest level of education completed:
☐9th grade or less ☐10th grade ☐11th grade
☐High School Graduate ☐GED ☐Training Certificate
☐Vocational ☐Associates ☐Bachelor ☐Master's
☐Advanced ☐Other:__________________________

Primary Adult **Lives with Child:** ☐ **Yes** ☐**No**

First Name: Last Name:
Date of Birth: Relationship To Child:
Is Parent/Guardian a: ☐GTB Member
☐Member of Another Tribe________________
Telephone Number/Contact Information:
Home:__________________ Work:________________
Cell Phone:_______________ Message:________________
E-Mail Address: ________________________________

Are you employed:
☐Part time ☐Full Time ☐Seasonally ☐US Military-Active Duty
☐Retired ☐Unemployed ☐Self Employed ☐Disabled
Employer Name:________________________________
Are you attending school/job training:
☐Yes ☐No
Highest level of education completed:
☐9th grade or less ☐10th grade ☐11th grade
☐High School Graduate ☐GED ☐Training Certificate
☐Vocational ☐Associates ☐Bachelor ☐Master's
☐Advanced ☐Other:__________________________

Other Household Member Information: Please list *all* other persons living within the home not listed above

First Name	Last Name	Date of Birth	Relationship to Child

Additional Information:

Is there anyone in your household currently pregnant? ☐No ☐Yes Due Date:____________________

Child Care Provider Information:

Will this child be cared for by someone other than you, in addition to participating in this program? ☐Yes ☐No
If yes, please complete the following information:

☐Child Care Center ☐Relative's Home or at Child's home by Relative
☐Family Child Care Home ☐Other:__________________________
☐Need assistance finding child care

_____ Number of hours per day child care is needed

Family Resource Information:

Does your family receive any of the following types of services or financial assistance? (Check all that apply)

☐Medicaid/Medicare ☐WIC - County________________ ☐Supplemental Security Income (SSI) ☐Refugee Assistance Program	☐SNAP/Bridge Card ☐Child Support ☐State Disability Assistance (for yourself or someone in your care)	☐Cash Assistance (from DHS) ☐Child Care Assistance (from DHS) (Tribal) ☐State Emergency Relief Programs ☐Other: __________________

What is your current living arrangement/situation: ☐Own ☐Rent ☐Motel ☐Receive Subsidized Housing
☐Shelter ☐Experiencing homelessness—live with others because I have no alternative ☐Live with relatives/friends by choice
How long have you lived at this address:____________ ☐Other, Specify____________________

In order to best meet the needs of your family, please indicate if your family receives or is in need of any of the following services:
Please write an "N" in the box by those services that you need or would like additional information, and write an "R" in the box by those services that you are currently receiving.

☐Crisis Assistance ☐Food ☐Housing ☐Clothing ☐Transportation ☐Parenting Education ☐Employment	☐Mental Health ☐Literacy ☐English as a Second Language ☐Adult Education ☐Relationship/Marriage Education ☐Legal Assistance	☐Job Training ☐Substance Abuse Prevention ☐Substance Abuse Treatment ☐Child Abuse/Neglect Services ☐Prenatal Education	☐Budgeting Information ☐Domestic Violence Services ☐Child Support Assistance ☐Health Education ☐Assistance to families of Incarcerated Individuals ☐Other:______________

Health, Nutrition & Developmental Information:

Applicant's Physician/Health Care Provider Name:	Address:	Date of Last Exam:

Health Care Coverage Information:
☐Medicaid ID #____________________________ ☐Contract Health ☐No Health Care Coverage
☐Private Health Insurance Policy #______________________________

Applicant's Dentist/Dental Care Provider Name:	Address:	Date of Last Exam:

Dental Coverage Information: ☐No Coverage ☐Medicaid ☐Private Insurance (please list):

Does the applicant have any health conditions such as: Allergies (to foods, medications, insect bites, seasonal, etc.), Diabetes, Asthma, Seizures, or any other conditions? ☐Yes ☐No (If yes, medical documentation is needed)
If yes, please list and explain if there is a protocol for emergency intervention:____

Does the applicant have any special dietary needs? ☐Yes ☐No Are they diagnosed by a health care professional? ☐Yes ☐No
If yes, please explain:____

Do you have any concerns about your child's development? ☐Yes ☐No
If yes, please describe:____

Child's Birth Weight: _____lb _____oz

Was child born more than 3 weeks early or late? ☐Yes ☐No
If yes, please explain:

Did the child's mother visit the doctor LESS than 2 times during pregnancy?
☐Yes ☐No

Did the child's mother have any health problems during pregnancy or delivery of this child?
☐Yes ☐No
If yes, please explain:____

Has your child been diagnosed with a disability? ☐Yes ☐No
If yes, please list:____

Is the applicant receiving any special services or currently on an IEP (Individual Education Plan) or IFSP (Individual Family Service Plan)? (i.e., medical, speech therapy, physical therapy, occupational therapy, early childhood special education, etc.)
☐Yes ☐No
If yes, please describe and list name of provider:____

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 within the agency and is accessible to me during normal business hours. I understand that this is an application only and does not guarantee enrollment into the Early Head Start/Head Start/GSRP Programs.

Parent/Guardian Signature: **Date:**

FOR OFFICE USE ONLY

Interview completed in person ☐ By phone ☐

Applicant interviewed by: Date: Birth Verified ☐Yes ☐No Income Verified ☐Yes ☐No

GTB EARLY HEAD START, HEAD START & GSRP
2600 N. Strongheart Way
Suttons Bay, MI 49682
(231)534-7650 / FAX (231)534-7583

revised 4/2019

CONSENT FOR PARTICIPATION

Expectant Mother's Name:______________________________________

I, the undersigned, hereby give permission to the Grand Traverse Band Early Head Start/Head Start/GSRP Programs to:

PLEASE INITIAL:

Release and Obtain my health records to and from my primary care physician and dental care provider

________ Obtain and share information regarding myself with DHHS.

________ Obtain and share information regarding myself with Health Department/WIC.

________ Obtain and share information regarding myself with GTB Behavioral Health Services.

________ Obtain and share information regarding myself with AFS.

________ Obtain and share information regarding myself with Pine Rest/Mental Health Therapist/Consultant________________________.

________ Allow me to participate in Head Start's Free Health Care Program which could include all or some of the following:

*Immunization Clinic	*Dental Examination
*Referrals to other agencies for Disabilities	*Hearing and Vision Testing
*Height and Weight measurements	* Hemoglobin & Blood Pressure Screening
*Physical examinations	
*Staff consultations regarding myself with Mental Health Consultant, Nutrition/Dietician Consultant, and/or Nursing Consultant if needed.	

________ To take photographs and/or videos of myself/family which may be used in displays, recruitment, or other types of news/educational publications. Occasionally local news media may take photographs or video of the children.

**This consent is valid for one year after the date signed. In signing this document, I am fully aware of the items listed and concur that the above consent is in the best interest of myself.

____ ______________________________

Signature of Parent/Guardian Date

Grand Traverse Band
Early Head Start
Pregnancy History and Tracking Form

Name	*Date Completed*

CURRENT PREGNANCY

Expected Delivery Date:

Length of Pregnancy: ☐*Less than 12 Weeks* ☐*12-24 Weeks* ☐*24+ Weeks* ☐*Don't Know*

Date of First Prenatal Care Visit:

Date of Last Dental Examination:

Prenatal Care Provider Information ☐*No Prenatal Care Provider*

Provider Name:	*Phone number:*

Street Address:

City:	*State:*	*Zip Code:*

Prenatal Care ☐*No Prenatal Visits*

Date of last Prenatal Visit:	*Date of Next Scheduled Exam:*	☐*No exam scheduled*

Number of Prenatal Visits since the first: ☐*Don't remember*

Time since last pregnancy: ☐*No previous pregnancy* ☐*Less than 18 months* ☐*More than 18 months*

PREVIOUS PREGNANCIES

Number of previous pregnancies: ☐*No previous pregnancies*

Number of full-term live births: *Number of Multiple Gestations:*

Number of Pre-term live births: *Number of Ectopic Pregnancies:*

Number of Miscarriages:

Number of Fetal deaths/stillborns:

COMMENTS:
Please list any questions or concerns you may have about your pregnancy