

Providing Quality Early Learning Services in Olmsted and Freeborn Counties



Early Head Start

- For eligible pregnant mothers or children up to age 3
- **And you live in the City of Albert Lea or Olmsted County**
 - Year-round programming
 - Home Visits (# depends on program option)
 - Socializations for Parents and Children
 - Child Health Screenings
 - Child Development Education
 - Family Support
 - Services available for children with special needs
 - Transportation may be available
 - Several program options are available



Head Start

- **For eligible children age 3 or 4 on or before September 1, 2010**
- **And you live in Freeborn County or Olmsted County**
 - Programming runs September through May
 - Home Visits (# depends on program option)
 - Parent Child Activity Days
 - Child Health Screenings
 - Child Development Education
 - Family Support
 - Services available for children with special needs
 - Transportation may be available
 - Several program options are available



- **For children age 3 or 4 on or before September 1, 2010**
- **And you are income eligible and live in Olmsted County**

School Readiness staff will work with families to develop an individualized plan for each child that may include some, or all of the following services:

- Programming runs September through May
- Preschool Scholarships
- Parent Education and Support
- Home Visits during school year
- Health and Community Service Referrals
- Parent Involvement, Family Events and Activities
- Consultation with Parents and Teachers

PLEASE COMPLETE THE STEPS BELOW BEFORE TURNING IN YOUR APPLICATION

- Complete pages 1 through 5 of the application with signature and date on page 5.
- For Olmsted County families with children age 3 or 4 on or before September 1, 2010 who are applying for School Readiness OR BOTH Head Start and School Readiness, please complete the Release of Information form on page 6.
- Attach Proof of Income for EACH parent/guardian living in your home (please refer to pages 4 and 5 of the application to be sure that you have included all sources of income that you have checked).
- Attach an immunization record for each child for whom you are applying.
- Mail or drop off your application at Child Care Resource and Referral, 126 Woodlake DR SE, Rochester, MN 55904, or fax to 507-287-2411.

We will do our best to enroll your child in the program that you prefer. However, funding and space are limited so we cannot guarantee enrollment. Placements are made according to child and family needs, parent choice, and available openings.

IMPORTANT: WE MUST HAVE PROOF OF YOUR FAMILY'S INCOME BEFORE WE CAN PROCESS YOUR APPLICATION



- * Para información en Español véase atras de esta página.
- * Akhbaata Soomaaliqa ama Carabiga ka fiiri gadaasha bogaan.

In Olmsted County

For English call 507-287-2009, ext. 221 or 290
For Spanish call 507-287-2009, ext. 290
For Somali call 507-251-6613

In Freeborn County

For English call 507-379-5160
For Spanish call 1-800-462-1660, ext. 212
For Somali call 507-251-6613

*“Ensuring positive beginnings for all young children and their families.”
Child Care Resource & Referral, Inc. is an equal opportunity provider and employer.*

**Income, age and place of residence determine your eligibility.
Please see the income guidelines listed below.**

Early Head Start, Head Start and School Readiness Annual Income Guidelines Effective until March 1, 2010 (please call after March 1, 2010, for updated guidelines)		
Size of Family Unit	Early Head Start and Head Start Annual Income Guideline	School Readiness Maximum Annual Income (Parent Share ranges from \$15 to \$59 per month)
1	Equal to or less than \$10,830 *	Equal to or less than \$24,540 *
2	Equal to or less than \$14,570 *	Equal to or less than \$31,459 *
3	Equal to or less than \$18,310 *	Equal to or less than \$38,378 *
4	Equal to or less than \$22,050 *	Equal to or less than \$45,297 *
5	Equal to or less than \$25,790 *	Equal to or less than \$52,216 *
6	Equal to or less than \$29,530 *	Equal to or less than \$59,135 *
7	Equal to or less than \$33,270 *	Equal to or less than \$66,054 *
8	Equal to or less than \$37,010 *	Equal to or less than \$72,973 *
	For family units with more than 8 members, add \$3,740 for each additional member to determine annual income.	For family units with more than 8 members, add \$6,919 for each additional member to determine annual income.

* Families who regularly receive MFIP (or out of state TANF funding), DWP, SSI, Child Care Assistance, Emergency Assistance or General Assistance Money are eligible for Early Head Start, Head Start and School Readiness even if their family income exceeds the income guidelines listed above. Foster children or families meeting the McKinney-Vento Act Definition of Homelessness are also eligible for both programs.

To understand what to send in for proof of your family's income please refer to the top of page 5 of the application.

(English)

If you have questions or want to schedule an appointment for help, please call 507-287-2009 or 1-800-462-1660 and ask for extension 221 or 290. If there is no answer leave a message with your name, the county you live in, and your phone number. We will return your call as soon as possible.

(Español)

Si usted tiene alguna pregunta o necesita ayuda para llenar esta solicitud por favor llame en el condado de Olmsted al tel. 507-287-2009 y pregunte por la extensión 290. Si usted se encuentra en el condado de Freeborn y necesita hablar con un intérprete de idioma español por favor llame al tel. 1-800-462-1660 extensión 212. Si nadie le responde deje un mensaje indicando su nombre, la ciudad donde vive y su número de teléfono, así como el horario de preferencia para devolverle la llamada. Haremos todo lo posible para comunicarnos con usted tan pronto como nos sea posible.

(Somali)

Haddii aad sua'al qabtid ama aad dooneysid in lagaa caawiyo buuxinta arjigaan Fadlan soo wac 287-2009 weydiiso 221. Haddii aad jeceshahay in aad la hadasho qof Soomali ah fadalan soo wac 251-6613. Haddii aan lagu jawaabin u reeb fariin gaaban magacaada, meeshaad degantahy iyo numbarka telefonkaada. Waa lagugu soo celin doonaa siida ugu dhaqsi badan.

Child Care Resource & Referral, Inc.
Application for Early Head Start, Head Start & School Readiness

For Office Use Only
 OC FC EHS HS SR Both HS & SR

FILL OUT ENTIRE APPLICATION, PLEASE PRINT CLEARLY. If you need help, please call (507) 287-2009 or 1-800-462-1660 and ask for extension 221 or 290.

Parent/Guardian First Name	Parent Guardian Last Name	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth ____/____/____ month day year	Language most often spoken in your home: <i>(mark only ONE box)</i> <input type="checkbox"/> Arabic <input type="checkbox"/> English <input type="checkbox"/> Somali <input type="checkbox"/> Spanish <input type="checkbox"/> Other <i>(please specify)</i> _____	Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Race <i>(mark ALL that apply)</i> <input type="checkbox"/> American or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White	Ethnicity: <i>(mark ONE)</i> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	Highest Education Level: <input type="checkbox"/> Grade 11 or less <input type="checkbox"/> High School Graduate or GED <input type="checkbox"/> Associate Degree/College Degree/ Training Certificate <input type="checkbox"/> Bachelors Degree <input type="checkbox"/> Masters Degree or higher	Employment status <i>(mark ALL that apply)</i> <input type="checkbox"/> Full Time (35 hours/week or more) <input type="checkbox"/> Retired or Disabled <input type="checkbox"/> Full Time and Training <input type="checkbox"/> Seasonally Employed <input type="checkbox"/> Part Time (under 35 hours/week) <input type="checkbox"/> Training or School <input type="checkbox"/> Part Time and Training <input type="checkbox"/> Unemployed
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Other Parent/Guardian First Name <i>(if living with you)</i>	Other Parent/Guardian Last Name <i>(if living with you)</i>	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth ____/____/____ month day year	Language most often spoken in your home: <i>(mark only ONE box)</i> <input type="checkbox"/> Arabic <input type="checkbox"/> English <input type="checkbox"/> Somali <input type="checkbox"/> Spanish <input type="checkbox"/> Other <i>(please specify)</i> _____	Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Race <i>(mark ALL that apply)</i> <input type="checkbox"/> American or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White	Ethnicity: <i>(mark ONE)</i> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	Highest Education Level: <input type="checkbox"/> Grade 11 or less <input type="checkbox"/> High School Graduate or GED <input type="checkbox"/> Associate Degree/College Degree/ Training Certificate <input type="checkbox"/> Bachelors Degree <input type="checkbox"/> Masters Degree or higher	Employment status <i>(mark ALL that apply)</i> <input type="checkbox"/> Full Time (35 hours/week or more) <input type="checkbox"/> Retired or Disabled <input type="checkbox"/> Full Time and Training <input type="checkbox"/> Seasonally Employed <input type="checkbox"/> Part Time (under 35 hours/week) <input type="checkbox"/> Training or School <input type="checkbox"/> Part Time and Training <input type="checkbox"/> Unemployed
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Home Address	Apt. #	City	State	Zip Code	Email Address
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Home Phone (____) _____ - _____ **Cell Phone** (____) _____ - _____ **Work Phone** (____) _____ - _____ **Message phone** (____) _____ - _____

Name and contact information of one friend or relative that does not live in your household whom we can contact if we cannot reach you:
Name _____ Phone _____ Phone 2 _____ Address _____

Is your family expecting a baby? No Yes → **If yes, due date:** _____ **Are you applying for Early Head Start as a pregnant mother?** Yes No

Marital Status: Married Married, but living apart Single Single Living with Partner Divorced or Widowed

Transportation is not guaranteed. Can you or someone you know transport your child/ren to and from school if transportation is not available? Yes No

How did you find out about our programs? *(mark All that apply)*

<input type="checkbox"/> Adult Basic Education or other Adult Literacy Program	<input type="checkbox"/> Early Childhood Special Education	<input type="checkbox"/> Social or Human Service Agency
<input type="checkbox"/> Child Care Program	<input type="checkbox"/> Family or Friends	<input type="checkbox"/> Word of Mouth
<input type="checkbox"/> Early Childhood Screening	<input type="checkbox"/> Health Care Provider	<input type="checkbox"/> Other <i>(please specify)</i> _____

LIST ALL CHILDREN BIRTH TO AGE FOUR ON OR BEFORE SEPTEMBER 1, 2010, THAT YOU ARE APPLYING FOR.

Child Applicant

Child First Name		Child Last Name	
Gender M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth ____/____/____ month day year	Relationship to You <i>(fill in number code from below)</i> _____	Relationship to Other Parent <i>(fill in number code from below)</i> _____
Race (mark ALL that apply) <input type="checkbox"/> American or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White		Ethnicity (mark ONE) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
Mark the program below for which you are applying for this child: <input type="checkbox"/> Early Head Start (EHS) birth up to age 3 <input type="checkbox"/> Head Start (HS) age 3 & 4 <input type="checkbox"/> School Readiness (SR) age 3 & 4 <input type="checkbox"/> Both HS & SR		Does this child have medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which kind? <input type="checkbox"/> Medical Assistance <input type="checkbox"/> Minnesota Care <input type="checkbox"/> Other	
		List concerns, e.g., behavior, speech, medical, etc., you have about this child: _____	
		Does this child have an IFSP or an IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Child Applicant

Child First Name		Child Last Name	
Gender M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth ____/____/____ month day year	Relationship to You <i>(fill in number code from below)</i> _____	Relationship to Other Parent <i>(fill in number code from below)</i> _____
Race (mark ALL that apply) <input type="checkbox"/> American or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White		Ethnicity (mark ONE) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
Mark the program below for which you are applying for this child: <input type="checkbox"/> Early Head Start (EHS) birth up to age 3 <input type="checkbox"/> Head Start (HS) age 3 & 4 <input type="checkbox"/> School Readiness (SR) age 3 & 4 <input type="checkbox"/> Both HS & SR		Does this child have medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which kind? <input type="checkbox"/> Medical Assistance <input type="checkbox"/> Minnesota Care <input type="checkbox"/> Other	
		List concerns, e.g., behavior, speech, medical, etc., you have about this child: _____	
		Does this child have an IFSP or an IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Child Applicant

Child First Name		Child Last Name	
Gender M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth ____/____/____ month day year	Relationship to You <i>(fill in number code from below)</i> _____	Relationship to Other Parent <i>(fill in number code from below)</i> _____
Race (mark ALL that apply) <input type="checkbox"/> American or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White		Ethnicity (mark ONE) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
Mark the program below for which you are applying for this child: <input type="checkbox"/> Early Head Start (EHS) birth up to age 3 <input type="checkbox"/> Head Start (HS) age 3 & 4 <input type="checkbox"/> School Readiness (SR) age 3 & 4 <input type="checkbox"/> Both HS & SR		Does this child have medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which kind? <input type="checkbox"/> Medical Assistance <input type="checkbox"/> Minnesota Care <input type="checkbox"/> Other	
		List concerns, e.g., behavior, speech, medical, etc., you have about this child: _____	
		Does this child have an IFSP or an IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Child Applicant

Child First Name		Child Last Name	
Gender M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth ____/____/____ month day year	Relationship to You <i>(fill in number code from below)</i> _____	Relationship to Other Parent <i>(fill in number code from below)</i> _____
Race (mark ALL that apply) <input type="checkbox"/> American or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White		Ethnicity (mark ONE) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
Mark the program below for which you are applying for this child: <input type="checkbox"/> Early Head Start (EHS) birth up to age 3 <input type="checkbox"/> Head Start (HS) age 3 & 4 <input type="checkbox"/> School Readiness (SR) age 3 & 4 <input type="checkbox"/> Both HS & SR		Does this child have medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which kind? <input type="checkbox"/> Medical Assistance <input type="checkbox"/> Minnesota Care <input type="checkbox"/> Other	
		List concerns, e.g., behavior, speech, medical, etc., you have about this child: _____	
		Does this child have an IFSP or an IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No	

NUMBER CODES FOR RELATIONSHIP TO YOU/OTHER PARENT: 1—Birth Child, 2—Step Child, 3—Foster Child, 4—Adopted Child, 5—Grand Child, 6—Niece, 7—Nephew, 8—Other Relative, 9—Not Related

LIST ALL OTHER ADULTS AND CHILDREN NOT LISTED ON PAGES 1 AND 2 THAT ARE LIVING IN YOUR HOUSEHOLD.

First Name	Last Name	Gender	Date of Birth	Relationship to You <i>(fill in a number code from below)</i>	Relationship to Other Parent <i>(fill in a number code from below)</i>
1		M <input type="checkbox"/> F <input type="checkbox"/>	____/____/____ month day year		
2		M <input type="checkbox"/> F <input type="checkbox"/>	____/____/____ month day year		
3		M <input type="checkbox"/> F <input type="checkbox"/>	____/____/____ month day year		
4		M <input type="checkbox"/> F <input type="checkbox"/>	____/____/____ month day year		
5		M <input type="checkbox"/> F <input type="checkbox"/>	____/____/____ month day year		
6		M <input type="checkbox"/> F <input type="checkbox"/>	____/____/____ month day year		

NUMBER CODES FOR RELATIONSHIP TO YOU/OTHER PARENT: 1—Birth Child, 2—Step Child, 3—Foster Child, 4—Adopted Child, 5—Grand Child, 6—Niece, 7—Nephew, 8—Brother, 9—Sister, 10—Mother, 11—Father, 12—Other Relative, 13—Not Related

Have any of the children that you are applying for been enrolled in Head Start or Early Head Start in a county other than Olmsted or Freeborn? Yes No

If yes, Child's Name _____ Dates of Attendance: From ____/____/____ To ____/____/____ County _____ State _____
month year month year

If yes, Child's Name _____ Dates of Attendance: From ____/____/____ To ____/____/____ County _____ State _____
month year month year

Please mark ALL circumstances listed below that have affected your family. *(This information helps us to know a little more about your child's and family's needs so that we can determine your child's priority status.)*

- | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Parent in jail or prison | <input type="checkbox"/> Child has a documented special need <i>(please explain)</i> : _____ |
| <input type="checkbox"/> Family violence/domestic abuse/Order of Protection in place | <input type="checkbox"/> Serious medical concern or disability of child's parent or sibling |
| <input type="checkbox"/> Child Protection involvement | <input type="checkbox"/> One or more family members without health insurance |
| <input type="checkbox"/> Abuse of alcohol or drugs by one or both parents | <input type="checkbox"/> Refugee statue or moved to the U.S. within the child's lifetime |
| <input type="checkbox"/> Parent, child, or sibling in counseling or being treated for a mental health concern | <input type="checkbox"/> Current military deployment of parent |
| <input type="checkbox"/> Death of child's parent or sibling | <input type="checkbox"/> Moved four or more times in the child's lifetime |
| <input type="checkbox"/> Currently a high risk pregnancy | <input type="checkbox"/> Moved to Minnesota from another state in the last year |
| <input type="checkbox"/> Bankruptcy, job loss, or other financial hardship resulting in an inability to provide your family with needed food, housing, medical care or clothing | |
| <input type="checkbox"/> Other concerns <i>(please explain)</i> : _____ | <input type="checkbox"/> NONE |

ELIGIBILITY

YOU ARE REQUIRED TO SUBMIT PROOF OF INCOME FOR EACH PARENT/GUARDIAN LIVING IN THE HOME.

1. Are you a **Foster Parent** to any of the children you are applying for? No Yes —————> **If yes, you must provide documentation from the county verifying the child’s foster care placement.**

2. Does your family receive any of the following benefits? No —————> **If no, skip to Question 3.**
 Yes —————> **If yes, mark the ones you receive and attach a letter or statement from the funding agency showing the monthly benefit amount. Then skip to Page 5.**
 MFIP or TANF Cash or Food DWP SSI Emergency or General Assistance Money Foster Care/Kinship Care Grant Refugee Grant

3. **Mark all sources of your family’s income listed below. Then mark the boxes under You, and Other Parent Living With You if applicable, to show who receives this income. Finally, submit documentation of all income with this application. Note: the information at the top of the next page explains how to prove income.**

	<u>You</u>	<u>Other Parent Living With You</u>
<input type="checkbox"/> Wages/Tips/Salary/Cash From Employment (If “Cash,” see “Work for Cash” instructions in box on top of Page 5.)		
<input type="checkbox"/> Self-Employment Income Net Income		
<input type="checkbox"/> Court Ordered Child Support/Spousal Maintenance/Alimony		
<input type="checkbox"/> Social Security Benefits (Disability/Retirement/Survivors)		
<input type="checkbox"/> SSI (verification needed for each family member receiving)		
<input type="checkbox"/> Regular Support (including Child Support by Parent Agreement or Military Family Allotments) From Someone Not Living In Your Home		
<input type="checkbox"/> Reemployment (Unemployment) Compensation		
<input type="checkbox"/> Financial Aid for School—Grants/Scholarships/Assistantships/Fellowships/Training Stipends. (Student loans are not counted.)		
<input type="checkbox"/> Workman’s Compensation		
<input type="checkbox"/> Pensions/Retirement Pay (Including Military and Railroad)		
<input type="checkbox"/> Strike Benefits from Union Funds		
<input type="checkbox"/> Income from Renting Out a Room, an Apartment, etc.		
<input type="checkbox"/> Veterans Benefits		
<input type="checkbox"/> Dividends, Interest, or Periodic Receipts from Estates/Trusts		
<input type="checkbox"/> Regular Insurance or Annuity Payments		
<input type="checkbox"/> Net Income from Royalties, or Gambling/Lottery Winnings		
<input type="checkbox"/> Other Income (<i>please explain</i>)		
<input type="checkbox"/> No Income/No Assistance received in the last 12 months (If “No Income/No Assistance.” see instructions in the box on top of Page 5.)		

How to Prove Income. Employment: (1) pages 1 and 2 of your 2009 joint or individual U.S. Income Tax Return **or** (2) all 2009 W-2 Forms **or** (3) a written statement or printout from your employer(s), **or** (4) at least 3 consecutive pay stubs reflecting average wages; Self-Employment Net: pages 1 and 2 of Form 1040 and Schedule C or a monthly ledger report; Social Security or Veteran's Benefits, Financial Aid for School, Pensions, Workman's Compensation, Military Family Allotments, or Similar Income: an official letter or recent statement from the funding agency showing the recipient's name, benefit amount, and how often received; Re-employment (Unemployment) Compensation: printout of payment(s) received with the remaining balance stated or an official letter from the funding agency showing the initial maximum benefit amount; Court Ordered Child Support or Spousal Maintenance: a 12-month printout if support is inconsistent **or** a monthly statement if support is consistent in amount and regularly received; Support From Someone Not Living In Your Home That Is Regularly Received (including child support by parent agreement): a copy of a check stub or a signed statement declaring the total amount of income received from this source in the past 12 months; Work for Cash: attach a signed and dated statement explaining your total cash income from all sources in the past 12 months; Other Income: a copy of your joint or individual U.S. Tax Return; No Income or Assistance for the past 12 months: attach a signed and dated statement indicating the month and year when you started having no income and no assistance. Then state how you provided your family with the basic necessities (food, housing, clothing, etc.) during this time period.

4. **What is your current living situation? Mark ONE.**

- Own, Rent or Share housing by choice
- Temporarily sharing housing because of loss of housing or economic hardship
- Staying at a Shelter or in other Transitional Housing
- Living in a Motel, Hotel, or Campground because affordable housing is unavailable
- Living in Substandard Housing without electricity or water
- Other (please explain) _____

5. **Do you receive Child Care Assistance (CCA) from Child Care Resource & Referral, Inc. or your county's Financial Assistance Department to pay for child care?**

No Yes —————> If yes, attach verification of CCA from your worker (a confirmation or redetermination letter, etc.), and print the Child Care Center or Child Care Provider's name & address:

Child Care Center or Child Care Provider's Name	Address	City	ST	Zip

6. **Do you have a 50/50 physical custody agreement for the child or children applying for Early Head Start, Head Start, and/or School Readiness?**

No Yes —————> If yes, list each child's name and the name of the parent you share custody with.

	Child's Name	Parent Name
	Child's Name	Parent Name

Note: If one of the parents receives Public Assistance or Child Support from the other parent, please send proof of income only for the parent receiving Public Assistance or Child Support. If neither parent receives Public Assistance or Child Support from the other parent, please send proof of income for BOTH parents.

Did someone help you fill out this application? No Yes —> If yes, Name of person helping you: _____ Phone # (_____) _____ - _____

Their relationship to you (e.g., friend, Social Worker, sister, neighbor, etc.) _____ May we contact this person regarding your application? Yes No

I hereby certify that all the information provided in this application is true and correct to the best of my knowledge. Agency officials may verify the information. I have read and removed the Data Privacy Rights of Applicants on Page 7 of this application to retain for my records.
Print & sign your name below & fill in date.

Parent/Guardian name _____ **Date** _____

Please **PRINT** your name clearly on this line Please **SIGN** your name on this line

Please return proof of family income and this application to: Child Care Resource & Referral, Inc., 126 Woodlake DR SE, Rochester MN 55904-5533
 507-287-2009 * 1-800-462-1660 * Fax 507-287-2411 *Thank you for your interest in Early Head Start, Head Start and School Readiness.*
 Child Care Resource & Referral, Inc., is an equal opportunity provider and employer.

ATTENTION: Olmsted County families with children age 3 or 4 on or before September 1, 2010

If you qualify for Head Start you also qualify for the School Readiness Program in Olmsted County.

Head Start and School Readiness staff will do their best to enroll your child in the program option that you prefer. However, funding and space are limited so we cannot guarantee enrollment. Because both programs fill up quickly, it would benefit your child and family to apply for both Head Start and School Readiness.

By completing the information below you are giving permission to CCRR School Readiness to exchange child/family information which may include health, school, work, attendance, parent share, developmental and enrollment information with the early childhood program your child will or currently attends.

This Release of Information only pertains to children who may be placed in the School Readiness Program.

SCHOOL READINESS RELEASE OF INFORMATION 2010-2011

TO BE COMPLETED BY ALL FAMILIES THAT ARE APPLYING FOR SCHOOL READINESS OR BOTH HEAD START AND SCHOOL READINESS

Clearly print the name of each child age 3 or 4 years old on or before September 1, 2010, for whom you are applying.

Child's Name: _____
(PRINT first name) (PRINT last name)

Child's Name: _____
(PRINT first name) (PRINT last name)

Child's Name: _____
(PRINT first name) (PRINT last name)

Child's Name: _____
(PRINT first name) (PRINT last name)

**** Your signature here indicates that you have read and understand the information stated above. This authorization will expire one year from the date listed below. ****

Parent/Guardian Name _____
Please PRINT your name clearly on this line Please SIGN your name on this line Date _____

PLEASE READ AND KEEP FOR YOUR RECORDS

DATA PRIVACY RIGHTS OF APPLICANTS OF CHILD CARE RESOURCE & REFERRAL, INC.

RIGHT TO KEEP INFORMATION ABOUT YOU PRIVATE (DATA PRIVACY)

Most of the information we collect about you will be classified as private. That means you and the agency collecting the data can see it; others cannot. Occasionally, statistics and other anonymous data will be taken from the information we collect about you or your family. This is public and open to anyone, but it will not identify you in any way.

In a few cases, information we collect is classified confidential. Confidential data is not open to anyone (not even you) except the government agencies that need it. Data in this category deals with civil or criminal investigation, some medical data, and the names of persons who report child or vulnerable adult abuse.

Purpose of Information

The information you are asked to provide will be used to determine program eligibility, to coordinate services between programs, to verify program services being provided, and to provide us with a mailing list. This list will be used to update you on upcoming programs and program changes and to inform you of eligibility for programs within Child Care Resource & Referral (CCRR), Inc. Only Head Start or School Readiness CCRR staff and funding source employees whose jobs require access to this information, as well as Federal or State Auditors, may have access to your information.

RIGHT TO ACCESS YOUR RECORDS

Access by you. You can see all public and private records about yourself and your children. To see your file, call Child Care Resource & Referral during agency hours and make a request to review your files within five working days by contacting the program from which you are receiving service. Review will take place on site during working hours.

Access by agency. Employees of this agency will have access to information about you any time their work requires it. By law, some other government and contractor agencies will also have access to certain information about you if they provide a service to you or if they provide a service to this agency that affects you and requires access to your records. They may include school districts, public health, social services and financial assistance.