

# Ute Indian Tribe Head Start

## Required Documents Check List

Dear Parent/Guardian:

Please read. Fill out the application. **All Information is required.** Incomplete applications will be delayed in the process of enrollment.

**Make sure you have all the documents listed below. Check all items that are included with this application:**

- Child's Birth Certificate
- Immunization Record: Must have all shots listed below or be on schedule.

Hepatitis A	Hepatitis B	Pneumococcal	Varicella chickenpox	Polio	Hib	DTaP	MMR
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- Income Verification for 12 months
  - o W2, 1040, 12 months of check stubs, Food Stamp Benefit Report, TANF Report, Child Support
- Family Interview Form (Head Start staff will provide when application is submitted).
- Court Documents – Guardianship
- Physical Exam
- Tuberculosis Risk Assessment Questionnaire
- Oral Health Form

**When you return this application, a Family Interview form will be completed with you and a member of the Head Start Staff.**

**Return application to the Head Start Administration Building: 6640 East Bottle Hollow Loop Road.**

**Questions? Call (435) 722-4506**



**Ute Indian Tribe Head Start**  
 P.O. Box 265  
 Fort Duchesne, Utah 84026  
 Office: 435 – 722-4506, FAX: 435-722-5652

**2021-2022 Enrollment Application**



Please fill out the form completely and accurately. All information will be kept Confidential. The information will be used to help us determine your family’s eligibility for Head Start. Please return this application to the Head Start Administration building.

**Return with: Your Child’s Birth Certificate, Immunization Record and Income Verification.**

**Class Preference:**  Half Day 9:00 am – 1:00 pm (child rides the bus)  Full Day 8:00 am – 4:30 pm (Parent Transport)

**Child Applicant (Print Clearly)**

Child’s Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 (First, Middle, Last)

Social Security Number \_\_\_\_\_ Sex:  Male  Female

**Race:**(check all that apply)

- American Indian or Alaskan Native       Asian       Black or African American
- Native Hawaiian/Pacific Islander       White       Other \_\_\_\_\_
- Enrolled Member of the Ute Indian Tribe
- Descendent of the Ute Indian Tribe

**Ethnicity:** (choose one)

- Hispanic       Non-Hispanic
- What language does your child speak most fluently?  English       Spanish       Other \_\_\_\_\_
- Does your child speak another language?  No       Yes If yes, what is the language? \_\_\_\_\_

**Parent/Guardian Information (Print Clearly)**

Parent/Guardian Name \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home phone: \_\_\_\_\_

**Race:** (check all that apply)

- American Indian or Alaskan Native       Asian       Black or African American
- Native Hawaiian/Pacific Islander       White       Other \_\_\_\_\_
- Enrolled Member of the Ute Indian Tribe       Descendant of Ute Indian Tribe

## **Parent/Guardian Information (continued)**

**Ethnicity:** (choose one)  Hispanic  Non-Hispanic

What Language do you prefer to communicate?  English  Spanish  Other: \_\_\_\_\_

**Highest Grade completed:**

- |  |  |
|--|--|
| <input type="checkbox"/> Less than High School (0-8) | <input type="checkbox"/> Associate Degree  |
| <input type="checkbox"/> High School Diploma         | <input type="checkbox"/> Bachelor's Degree |
| <input type="checkbox"/> GED                         | <input type="checkbox"/> Master's Degree   |

**Employment Status:**

- Full Time  Part Time  Seasonal  Homemaker  Unemployed, # of Months \_\_\_\_\_  
 Retired or Disabled

## **Other Parent or Guardian in the Household: (Print Clearly)**

**Parent/Guardian Name** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Home phone:** \_\_\_\_\_

**Race: (check all that apply)**

- |  |                                |  |
|--|--------------------------------|--|
| <input type="checkbox"/> American Indian or Alaskan Native   | <input type="checkbox"/> Asian | <input type="checkbox"/> Black or African American |
| <input type="checkbox"/> Native Hawaiian/Pacific Islander  | <input type="checkbox"/> White | <input type="checkbox"/> Other _____               |
| <input type="checkbox"/> Enrolled Member of the Ute Indian Tribe <input type="checkbox"/> Descendant of Ute Indian Tribe |                                |  |

**Ethnicity:** (choose one)  Hispanic  Non-Hispanic

What Language do you prefer to communicate?  English  Spanish  Other: \_\_\_\_\_

**Highest Grade completed:**

- |  |  |
|--|--|
| <input type="checkbox"/> Less than High School (0-8) | <input type="checkbox"/> Associate Degree  |
| <input type="checkbox"/> High School Diploma         | <input type="checkbox"/> Bachelor's Degree |
| <input type="checkbox"/> GED                         | <input type="checkbox"/> Master's Degree   |

**Employment Status:**

- Full Time  Part Time  Seasonal  Homemaker  Unemployed, # of Months \_\_\_\_\_

## **Family Size and Income**

This information is required by the Office of Head Start. The total number of people living in the household and income is used to determine if your family income is at or below the Federal Poverty guidelines. **Family means all persons living in the same household who are supported by the child's parent(s) or guardian(s) income; and are related to the child's parent(s) or guardian(s) by blood, marriage, or adoption; or are the child's authorized caregiver or legally responsible party.**

Number in the household \_\_\_\_\_ Number in family \_\_\_\_\_ Total number of children \_\_\_\_\_

Number of Age 0-3 \_\_\_\_\_

Number of Age 4-5 \_\_\_\_\_

**Names of People in Household**

(Print Clearly)

Name (First, Middle, Last)	Relationship to Child	Level of Education	Date of Birth	Race	Ethnicity
					<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
					<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
					<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
					<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
					<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
					<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
					<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic

**Please check the type of family that best describes that of the child applying to this program:**

- Single Parent     
 Two Parent     
 Married     
 Biological     
 Step Parent  
 Joint Custody     
 Foster Parent     
 Not the Child's Parent     
 Other

**Income**

Eligibility is based on the Federal Poverty Guidelines. Proof of Income is Required and must include the total income of all members of the family listed above.

**Do you receive TANF?** ( food stamps and emergency assistance not included)     Yes     No

**Do You or any one in your family currently receive Supplemental Security Income (SSI)?**    Yes     No

**Is this application for a foster child placed with you through Ute Tribe Social Services or the State of Utah?**

Yes       No

**Is your family currently Homeless?**    Yes       No

(living temporarily in a shelter, hotel, vehicle, or living with relatives or friends)

**Is one of the parent/guardian a member of the United States Military or on Active Duty?**    Yes    No

Is one of the parent/guardian a veteran of the United States Military?  Yes  No

### Income (continued)

Parent/Guardian please check all sources of income:

- Employment/Job       Military Income       Child Support       Pension  
 Unemployment       Alimony       Other \_\_\_\_\_

Are you receiving assistance from other agencies? Check all that you receive.

- Aid to Families with Dependent Children (AFDC)       Supplemental Nutrition Assistance Program (SNAP)  
 Food Stamps       Nutrition Program for Women, Infants and Children (WIC)

Other Parent/Guardian please check all sources of income:

- Employment/Job       Military Income       Child Support       Pension  
 Unemployment       Alimony       Other \_\_\_\_\_

Are you receiving assistance from other agencies? Check all that you receive.

- Aid to Families with Dependent Children (AFDC)       Supplemental Nutrition Assistance Program (SNAP)  
 Food Stamps       Nutrition Program for Women, Infants and Children (WIC)

### Transportation

Due to COVID-19, we are now limited to how many children we can transport on buses. Families living 2 miles from the Head Start centers will be parent transport. Children who live beyond the 2 miles will be transported. There will be no door to door pick up or drop off. Instead, there will be designated areas for pick up and drop off. The Transportation Specialist will contact you where the areas are.

Parent Transport will be required if you are unable to meet at a designated pick up/drop off location.

Designated routes will be established at the beginning of the year and will not be changed throughout the year. This is in compliance with Federal and State Law.

If my child is on a bus route, I give permission to the Ute Indian Tribe Head Start to transport my child to and from school. I have read, understand and will comply with the Ute Indian Tribe Head Start Transportation Policy.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Printed Name: \_\_\_\_\_

## Emergency Contact Information

(Print Clearly)

### Contact 1

<b>Parent/Guardian</b>	Relationship to child	<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Release Child to <input type="checkbox"/> Do Not Release Child to
Address: Language you prefer to speak:		
Cell #:	Home #	Work #

### Contact 2

<b>Name:</b>	Relationship to child	<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Release Child to <input type="checkbox"/> Do Not Release Child to
Address: Language you prefer to speak:		
Cell #:	Home #	Work #

### Contact 3

<b>Name:</b>	Relationship to child	<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Release Child to <input type="checkbox"/> Do Not Release Child to
Address: Language you prefer to speak:		
Cell #:	Home #	Work #

### Contact 4

<b>Name:</b>	Relationship to child	<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Release Child to <input type="checkbox"/> Do Not Release Child to
Address: Language you prefer to speak:		

Cell #:	Home #	Work #
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### Education Permissions

**What school district will your child attend for Kindergarten?**  Duchesne  Uintah

**Name of elementary School?** \_\_\_\_\_

- I give permission to the Ute Tribe Head Start to release my child's name and any information that may be needed to the public school that my child will transition into.
- I give permission to have additional assessments administered if necessary from the school district selected.
- I give permission to share health records with the school districted selected.
- My child may accompany his/her class on field trips.
- The Ute Indian Tribe Head Start may use my child's photographs for educational purposes such as on Head Start display boards, power point presentations, brochures and on social media to promote Head Start.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Printed Name: \_\_\_\_\_

### Developmental Concerns

**Do you have any concerns about your child?**  Yes  No

If Yes, check the area you have a concern:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Autism                  | <input type="checkbox"/> Emotional Behavior                    | <input type="checkbox"/> Learning Disability    |
| <input type="checkbox"/> Health Impairment       | <input type="checkbox"/> Hearing Impairment including deafness | <input type="checkbox"/> Orthopedic Impairment  |
| <input type="checkbox"/> Traumatic Brain Injury  | <input type="checkbox"/> Speech Language Impairment            | <input type="checkbox"/> Fetal Alcohol Syndrome |
| <input type="checkbox"/> Developmentally Delayed | <input type="checkbox"/> Visual Impairment including blindness | <input type="checkbox"/> Other _____            |

**Has your child been diagnosed with any of the above?**  Yes  No

If Yes, by whom: \_\_\_\_\_

### Mental Health

As part of the Office of Head Start requirements, a Mental Health Professional will observe each classroom and may make a referral for further observations

### Potty Training

**Does your child need help with Toilet Teaching (Potty Training)?**  Yes  No

If yes, explain \_\_\_\_\_

**Does your child wear Diapers?**  Yes  No If Yes, what size? \_\_\_\_\_

**Does your child wear Training Pants (pull ups)?**  Yes  No If Yes, what size? \_\_\_\_\_

Does your child have an allergy or sensitivity to any type or brand of diapers or wipes?  Yes  No

If yes, what is the allergy or sensitivity? \_\_\_\_\_

**Health (Print Clearly)**

Does your child have any health concerns or allergies? \_\_\_\_\_

**My Child's Doctor and Dentist (Print Clearly)**

Please write IHS for both Doctor and Dentist below if your child is eligible to receive services from the Indian Health Service (IHS). Please write None below if your child does not have a Doctor or Dentist.

<b>Doctor's Name</b>	Address	City	Zip	Phone
<b>Dentist's Name</b>	Address	City	Zip	Phone

**Insurance Information (Print Clearly)**

Medicaid Eligible?  Yes  No Medicaid Number: \_\_\_\_\_

Indian Health Service (IHS) eligible?  Yes  No

Primary Health Coverage?  Yes  No Insurance Provider \_\_\_\_\_

Dental Coverage?  Yes  No Insurance Provider \_\_\_\_\_

Other Health Coverage?  Yes  No Insurance Provider \_\_\_\_\_

**Consent and Permission**

By checking the boxes below, the Parent/Guardian gives consent to the Ute Indian Tribe Head Start to perform the following screenings:

*(If Parent/Guardian does not mark one or more of the screenings, the Parent/Guardian acknowledges responsibility for obtaining that required screening)*

**Provided by Head Start:**

Developmental Screening  Vision  Hearing  Heights and Weights

Treated with Emergency care if needed

**Provided by Dentist:**  Dental Screening  Fluoride Varnish

**Provided by Health Care:**  Blood Pressure  Physical Exam

**Finger Stick:**  Lead Screening  Hematocrit/Hemoglobin

**Consent to Ute Indian Tribe Head Start to provide screening.**



Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name: \_\_\_\_\_

### Nutritional Assessment (Print Clearly)

Does the child have Food Allergies? \_\_\_\_\_

Please check all that apply:

- |  |   |
|--|---|
| <input type="checkbox"/> Child takes vitamin and mineral supplements | <input type="checkbox"/> Child is on a Special Diet   |
| <input type="checkbox"/> Supplement contains Iron                    | <input type="checkbox"/> Child has had a change in appetite in the past month                                     |
| <input type="checkbox"/> Supplement contains fluoride                | <input type="checkbox"/> Child takes a bottle   |
| <input type="checkbox"/> Supplement was prescribed                   | <input type="checkbox"/> Child eats or chews things that are not food   |
| <input type="checkbox"/> Child has trouble chewing and swallowing    | <input type="checkbox"/> Child often has: <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation |

### Food Group Eating Frequency

How many times a day does the child eat or drink the following: Write how many times a day.

- |   |  |
|---|--|
| ___ Milk, cheese, yogurt                        | ___ Meat, poultry, fish, eggs or dried beans/peas, peanut butter |
| ___ Rice, grits, bread, cereal, tortillas       | ___ Greens, carrots, broccoli, winter squash, pumpkin, yams      |
| ___ Oranges, grapefruit, tomatoes (fruit/juice) | ___ Other fruits and vegetables                                  |
| ___ Oil, butter, margarine, lard                | ___ Cakes, cookies, sodas, fruit drinks, candies                 |

Favorite Foods: \_\_\_\_\_

Least Favorite Foods: \_\_\_\_\_

Foods not eaten for medical, religious, or personal reasons? \_\_\_\_\_

Concerns about what child eats? \_\_\_\_\_

### Fatherhood Program

The Ute Indian Tribe implements a Fatherhood Program. This program offers opportunities for Fathers to become engaged in their child's education. Activities are held every month. Please indicate below if you are interested in being involved in our Fatherhood Program.

- Interested  Not Interested

### Certification

I certify the information provided in this application is accurate and truthful to the best of my knowledge and authorize Head Start to verify information as needed.

Parent/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name: \_\_\_\_\_

\*This institution is an equal opportunity provider



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## Ute Indian Tribe Head Start

P.O. Box 265  
For Duchesne, Utah 84026  
Office: 435 – 722-4506, FAX: 435-722-5652

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Dear future Head Start family,

The Ute Indian Tribe Head Start program is required to ensure your child is receiving quality health care. We are supportive of your child's health and growth and want the best experience for them in Head Start. Attached are the Physical Exam, Tuberculosis Risk Assessment Questionnaire and Oral Health Assessment forms. Please make an appointment with your child's dentist and doctor. Take these forms to be filled out. When completed return them to the Head Start Administration Office.

IHS or Indian Health Services has asked those receiving services from them to schedule an appointment to complete a Nursing Appointment, Physical Exam and Oral Health Assessment as soon as possible. You can contact IHS at 435-722-5122.

Please schedule the Physical Exam and Oral Health Assessment with your child's health provider before school starts or as early as possible. Due to COVID-19, we may not be able to provide screenings. Thank you for your cooperation.

Sincerely,

Ute Indian Tribe Head Start  
Phone (435)722-4506  
Fax (435)722-5652

## Final Check

- **Please check to make sure you have filled out the application completely.**
- **An application not filled out with all information will be delayed in the process of acceptance into Head Start.**

### **Are all the required documents included?**

- Child's Birth Certificate
- Immunization Record
- Income Verification for 12 months
- Parent's Report Form: Self Help and Social Emotional Scales
- Court Documents – Guardianship (if applicable)
- Physical Exam
- Tuberculosis Risk Assessment Questionnaire
- Oral Health Form
- Family Interview Form (this will be filled out with a Head Start staff when application is turned in)

*Thank You!*