

ORANGE

Children Parents Together

Dear Parents/Guardians,

Thank you for your interest in applying for our Head Start/Early Head Start/ State Preschool **2016-2017** school year. Attached you will find the application and physical exam form. Once you completely fill out your application you can submit your application to one of our sites.

Proof of Birth

- Birth Certificate
- Foster Care Documents
- Court orders regarding child custody
- Adoption documents

Proof of Income

(All sources of income in the household for the past 12 months)

- W-2 Forms/Income Tax Forms
- Pay Check Stubs (at least 4 consecutive dates)
- Notice of Action letter for Cal-Works
- Supplemental Social Security
- Social Security Income
- Foster Care Reimbursement
- Child Support
- Unemployment/Disability
- Grants/Scholarships
- Self Declaration Letters

Proof of Identified Disability (if applicable)

- Individualized Education Plan (IEP)
- Individual Family Service Plan (IFSP)

Health Information

- Physical Exam
- Dental Exam
- TB test
- Immunizations
- Proof of Insurance
(If applicable)

Proof of Residence

- Utility bill
- Lease agreement

Applications that are incomplete or missing any eligibility documentation will require additional processing time. Once your application has been reviewed you will be contacted by a Family Support Worker regarding the status of your application. Please contact us if you have any questions at (714) 639-4000.

LOCATIONS

Administrative Office	1063 N. Glassell St, Orange	(714) 639-4000
California CDC	1080 N. California St, Orange	(714) 633-3859
Center CDC	18702 E. Center St, Orange	(714) 997-4980
Handy CDC	860 N. Handy St, Orange	(714) 289-1175
Hewes CDC	392 S. Hewes St., Orange	(714) 639-4187
Taft CDC	1829 N. Cambridge St., Orange	(714) 974-6310
West Orange CDC	243 S. Bush St, Orange	(714) 532-1300

ORANGE

Children Parents Together

Estimados Padres/Guardianes,

Gracias por su interés en aplicar para nuestro programa de Head Start/ Head Start de Temprana edad y programa Pre-escolar del Estado para el año **2016-2017**. Adjunto usted encontrara la aplicación con la forma para el examen físico. Una vez que complete la aplicación favor de someterla a uno de nuestros centros.

Comprobante de Fecha de Nacimiento

- Acta de Nacimiento
- Documentos de niño de crianza
- Documentos de la corte referente a custodia
- Documentos de adopción

Comprobante de Ingresos

(Todas las Fuentes de ingresos en su hogar por los últimos 12 meses)

- Formas W-2/ Formas de los Impuestos
- Talones de cheque (un mínimo de 4 fechas consecutivas)
- Notificación de Acción para CalWorks
- Supplemental Social Security
- Ingresos de Seguro Social
- Rembolso de niño de crianza
- Mantenimiento de niño
- Desempleo/Incapacidad
- Becas
- Cartas de Auto Declaración

Comprobante de Incapacidad Identificada (si es aplicable)

- Plan Educativo Individualizado (IEP)
- Plan Individual de Servicios Familiares (IFSP)

Información de Salud

- Examen físico
- Examen Dental
- Prueba de Tuberculosis
- Vacunas
- Comprobante de aseguranza (si es aplicable)

Comprobante de Vivienda

- Factura de servicios públicos
- Contrato de arrendamiento

Las aplicaciones que se entreguen incompletas o que les falten documentos de elegibilidad requieren más tiempo para procesar. Una vez que su aplicación sea revisada una Trabajadora de Apoyo Familiar se comunicara con usted para informarle sobre su aplicación. Si tiene preguntas favor de comunicarse con nosotros al (714) 639-4000.

LOCACIONES

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Children Parents Together

2016-2017

Application # _____ Elementary School/Primaria: _____

CHILD INFORMATION ~ INFORMACION SOBRE EL NIÑO/A

Child's legal Name: First _____ Last: _____
 Nombre legal del Niño: Primer _____ Apellido: _____

Child's Primary Language: _____ Sex: M / F Date of Birth _____
 Primer Idioma del Niño: _____ Sexo: _____ Fecha de Nacimiento _____

What is the child's ability to speak and understand English? Total Moderate Poor
 Cual es la habilidad de su niño/a para comprender o hablar Ingles? Total Moderado Poco

Ethnicity: (Circle one) Hispanic Asian Pacific Is. African American White Other
 Etnicidad: (Circule uno) Hispano Asiatico Is. Pacificas Afro-Americano Blanco Otro

Address: _____ City _____ Zip Code _____
 Domicilio _____ Ciudad _____ Codigo Postal _____

We are homeless. (This means your family is staying in a car, park, campground or hotel, emergency shelter or transitional housing or your family is living with another family temporarily) Yes No

No tenemos hogar. (Esto quiere decir que su familia esta viviendo en un carro, parque, terreno de campamento, hotel, albergue de emergencia, o vivienda transicional o su familia esta viviendo temporalmente con otra familia) Si No

Primary Phone/Telefono Principal () _____ - _____ Home/Casa Work/Trabajo Message/Mensaje Cell/Celular
 Alternate Phone/Telefono Alterno () _____ - _____ Home/Casa Work/Trabajo Message/Mensaje Cell/Celular

Does this child have medical coverage? Yes No Medi-Cal # _____ Private/Privado # _____
 Tiene el niño aseguranza medica? Si No Healthy Families # _____ Other/Otro # _____

Does this child have a disability or special education need? Yes No Suspected Does this child have an active IEP/IFSP? Yes No
 Tiene el niño alguna incapacidad o necesidad educacional especial? Si No Sospecho Tiene el niño un IEP/IFSP? Si No

Are you currently receiving WIC services? Yes No Actualmente esta recibiendo servicios de WIC? Si No

Are you currently receiving CalFresh (Food Stamps)? Yes No Actualmente esta recibiendo CalFresh (estampillas de comida)? Si No

FAMILY MEMBER INFORMATION ~ INFORMACIÓN ACERCA LOS MIEMBROS DE LA FAMILIA

"Family for a child, means all persons living in the same household who are: (1) Supported by the child's parent(s)', or guardian(s)' income; **and** (2) Related to the child's parent(s) or guardian(s) by blood, marriage, or adoption; **or** (3) The child's authorized caregiver or legally responsible party."
 Familia de el niño/a es toda persona que vivan en la misma casa que: (1) Son mantenidos por los ingresos del los padres o guardianes del niño/a; **Y** (2) El parentesco con el padre o guardian del niño/a es por sangre, matrimonio, o adopción; **o** (3) El cuidador autorizado o persona legalmente responsable del niño/a

Number of persons/ Numero de Personas: _____ In Family/ En Familia () _____

First and Last name of Parent or legal guardian/ Nombre y apellido de los padres o guardianes legales	Relationship to child Relacion con el niño/a	Education level Nivel de Educacion	Primary Language Primer Idioma	Date of Birth Fecha de Nacimiento
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A01				
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Employment/Empleo Full time/Tiempo Completo Part Time/Medio Tiempo Unemployed/Desempleado Homemaker/Ama de Casa Retired/Retirado Other/Otro

A02				
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Employment/Empleo Full time/Tiempo Completo Part Time/Medio Tiempo Unemployed/Desempleado Homemaker/Ama de Casa Retired/Retirado Other/Otro

First and last name of children in the home beginning with the child you are applying for. Nombre completo de los niños en su casa comenzando con el niño por el cual esta aplicando.	Date of Birth Fecha de Nacimiento	Sex Sexo	For Office Use Only/ Para Uso de Oficina Unicamente			
			Related to		How Related	

C01		M F	B12	A01	A02	N F G N O
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C02		M F	B12	A01	A02	N F G N O
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C03		M F	B12	A01	A02	N F G N O
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C04		M F	B12	A01	A02	N F G N O
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C05		M F	B12	A01	A02	N F G N O
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C06		M F	B12	A01	A02	N F G N O
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VERIFICATION AND PARENT SIGNATURE~VERIFICACION Y FIRMA DE PADRES

OCPT, Inc. is a nonprofit organization operating preschool programs funded by the Office of Head Start; all children and families must meet established eligibility guidelines in order to qualify for services. Providing knowingly false or incorrect information is strictly prohibited and will result in immediate termination from the program. **I swear under penalty of perjury and to the best of my knowledge, that the above information is true and correct.**

OCPT, Inc. es una organización que opera programas preescolares con fondos recibidos del la Oficina de Head Start, todos los niños y familias necesitan calificar bajo las guías de elegibilidad establecidas para poder calificar para los servicios. Proveer información falsa o incorrecta es estrictamente prohibido y resultara en terminacion inmediata del programa. **Yo juro bajo pena de perjurio y al mejor de mi conocimiento, que los datos declarados son verdaderos y correctos.**

Parent/ Legal Guardian's Signature - Firma del Padre/ Guardian

Date/ Fecha

**OFFICE USE ONLY-PARA USO DE LA OFICINA UNICAMENTE
ELIGIBILITY INFORMATION**

Father's Source of Income

[] Pay Stubs [] Self Declaration of Income [] Employment Verification Form [] Cal Works/TANF
 [] W2/Tax Forms [] Unemployment Benefits [] Disability Benefits [] Child Support -Alimony
 [] Unemployed, No income [] SSI (Supplemental Security Income) [] Other:

Mother's Source of Income

[] Pay Stubs [] Self Declaration of Income [] Employment Verification Form [] Cal Works/TANF
 [] W2/Tax Forms [] Unemployment Benefits [] Disability Benefits [] Child Support -Alimony
 [] Unemployed, No income [] SSI (Supplemental Security Income) [] Other:

HEAD START/EARLY HEAD START

INCOME ELIGIBILITY: Below 100% FPL Eligible for Public Assistance 100% -130% FPL Above 130% FPL

CATEGORICAL ELIGIBILITY: Homeless Foster Disability (IEP/IFSP) Yes No Total Annual Income: \$

ELIGIBILITY CRITERIA

Categorical Status	Points	Income Status	Points	Age	Points	Disability	Points	Parental Status	Points
Desc.		Desc.		Desc.		Desc.		Desc.	
Other 1	Points	Other 2	Points	Other 3	Points	Top Priority <input type="checkbox"/> Yes <input type="checkbox"/> No		Total Points:	
Desc.		Desc.		Desc.					
<input type="checkbox"/> Date of birth verified:				<input type="checkbox"/> Address verified: <input type="checkbox"/> OUSD <input type="checkbox"/> Other: _____					
Site preference:				Session preference: <input type="checkbox"/> AM <input type="checkbox"/> PM					
Signature of Authorized Agency Representative				Title			Date		

ORANGE CHILDREN & PARENTS TOGETHER, Inc.

Head Start & State Preschool

Child Pre-Admission Health Evaluation

Part A - Parental Consent - To be completed by Parent

_____, born on _____ is being evaluated for
(Name of Child) (Birth Date)

readiness to enter prekindergarten. Orange Children & Parents Together, Inc. operates prekindergarten 3.5 hours a day 4 to 5 days a week. Please provide a health report for my child using the form below.

I hereby authorize release of medical information contained in this report to Orange Children & Parents Together, Inc.

Signature of Parent, Guardian, or Authorized Representative

Today's Date

Part B - Physician's Report - To be completed by Physician

EPSDT REQUIRED EXAM

REQUIRED SCREENINGS

HGB _____ HCT _____

IRON PRESCRIBED:
 YES NO

RECHECK DATE _____

LEAD SCREEN HISTORY (AGE 2)

Result: _____

CURRENTLY NOT AT RISK

VISION RESULTS

PASSED R 20/____ L 20/____

FAILED R 20/____ L 20/____

UNABLE TO CONDITION

REFERRED TO _____

REQUIRED TB SKIN TEST

MUST BE WITHIN LAST 12 MONTHS

DATE GIVEN _____

DATE READ _____

MM INDURATION _____

SCREENED, NOT AT RISK

AUDITORY RESULTS

PASSED R _____ L _____

FAILED R _____ L _____

UNABLE TO CONDITION

REFERRED TO _____

GENERAL HEALTH

HEIGHT _____ WEIGHT _____

BLOOD PRESSURE _____

URINALYSIS N/A

IMMUNIZATION HISTORY - ATTACH A COPY OF CALIFORNIA IMMUNIZATION RECORD

PHYSICAL EXAMINATION

	NORMAL	ABNORMAL		NORMAL	ABNORMAL
GENERAL APPEARANCE	<input type="checkbox"/>	<input type="checkbox"/>	GLANDS	<input type="checkbox"/>	<input type="checkbox"/>
POSTURE/GAIT	<input type="checkbox"/>	<input type="checkbox"/>	HEART	<input type="checkbox"/>	<input type="checkbox"/>
SPEECH	<input type="checkbox"/>	<input type="checkbox"/>	LUNGS	<input type="checkbox"/>	<input type="checkbox"/>
HEAD	<input type="checkbox"/>	<input type="checkbox"/>	ABDOMEN	<input type="checkbox"/>	<input type="checkbox"/>
EYES	<input type="checkbox"/>	<input type="checkbox"/>	GENITALIA	<input type="checkbox"/>	<input type="checkbox"/>
EARS	<input type="checkbox"/>	<input type="checkbox"/>	BONES/JOINTS/MUSCLES	<input type="checkbox"/>	<input type="checkbox"/>
NOSE	<input type="checkbox"/>	<input type="checkbox"/>	SKIN	<input type="checkbox"/>	<input type="checkbox"/>
TEETH	<input type="checkbox"/>	<input type="checkbox"/>	BACK	<input type="checkbox"/>	<input type="checkbox"/>
FLUORIDE PRESCRIBED	<input type="checkbox"/> YES	<input type="checkbox"/> NO	OTHER	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS

PHYSICIAN INFORMATION

I have have not reviewed the above information with the parent/guardian

Physician: _____

Date Physical Exam: _____

Address: _____

Date Form Completed: _____

Telephone: _____

Signature: _____

Physician Physician's Assistant Nurse Practitioner