All Our Kin *Early Head Start*
Family Application Form

All information provided will remain completely confidential, and stored in a locked cabinet.
The All Our Kin staff maintains and respects every family's right to privacy.

The following application must be submitted along with copies of the following documents:

a. Copy of the **child's birth certificate**.

b. **Proof of income for all working adults in home**: can be either <u>two</u> most recent paystubs OR a copy of last year's W-2 OR a DSS/State Assistance Document, etc. If you currently have no income, please submit and sign a statement of no income. *Please note: you MUST submit pay stubs or tax returns for each adult living in the same home as your child.*

c. **Proof of address**: can be (most likely) a lease agreement, or a utility bill from light, gas, power companies, etc.

d. A State of Connecticut Health Assessment Record **including vaccination records**.

e. Most recent **child dental records**.

You may drop off copies of your completed application and documents to the All Our Kin office at 414A Chapel St. New Haven, CT 06511 between 9AM and 5PM, Monday-Friday, mail the application to P.O. Box 8477, New Haven, CT 06530, or fax it to us at (203) 772-2386. Please note that your application cannot be processed until we receive ALL required documents. Call Carmen, EHS Family Advocate, with any questions at 203-772-2294.

Please note:

All Our Kin's Early Head Start program encourages applications from families and children of all races, ethnicities, religions, nationalities, family structures, sexual orientations, genders, ages, and abilities. We are actively engaged in developing a culturally competent community that values equity, inclusion, and justice. Furthermore, we support the rights of *all* children to participate fully within the family child care setting. In this inclusive framework, children learn and play together, participation in daily activities is ensured through the practice of meeting individualized abilities, and each child's strengths, needs, and rights are valued. Through this process, the development of each child's sense of belonging, social relationships, skill growth, and learning is prioritized and maximized.

Thank you for your interest in Early Head Start!

CHILD & FAMILY INFORMATION

Child's Name: _____ Date of Birth: _____

Address:_____ City, State, Zip Code: _____

Guardian #1's Name:_____ Date of Birth: _____

Relationship to child: _____ Phone: _____ Currently lives with child?: Yes ☐ No ☐

Guardian #2's Name: _____ Date of Birth: _____

Relationship to child: _____ Phone: _____ Currently lives with child?: Yes ☐ No ☐

Emergency Contact's Name: _____ Phone: _____ Relationship to child: _____

HOUSEHOLD INFORMATION

Please include ALL people who currently live in the same home as your child

Name (Adults):	D.O.B.	Relationship to you	Race	Sex (M/F)	Language/s spoken	Employed	FT or PT?	Monthly income	School/ Training	FT or PT?
						Y N			Y N	
						Y N			Y N	
						Y N			Y N	
						Y N			Y N	

Name (Children):	D.O.B.	Relationship to you	Race	Sex (M/F)	Language/s spoken	Applying for Early Head Start?
						Y N
						Y N
						Y N
						Y N

Does the child have additional siblings that are NOT living at home? Please provide details below:

Name	DOB	Sex (M/F)	With whom does the sibling live?

What is the TOTAL number of people currently living in your home? _____

Are there any HOUSEHOLD changes that you expect over the coming year (births, moves, etc.)? Please describe below:

_____

1. Are you currently receiving any of the following benefits? If so, please specify dollar amount.
   - ☐ TANF $_____/month
   - ☐ SNAP (food stamps) $_____/month
   - ☐ SSI $_____/month
   - ☐ WIC $_____/month
   - ☐ DCF stipend $_____/month
   - ☐ Unemployment $_____/month
   - ☐ Court-ordered child support $_____/month
2. What is your family's current housing situation?
   - ☐ Rent home (is your name on the lease of the place where you're living? Yes / No)
   - ☐ Own home
   - ☐ Homeless (please specify where you are currently living, i.e. in a shelter or with family members _____)
   - ☐ Has your family moved in the last 12 months? Yes / No (if yes, how many times? _____)

3. Do either of your child's parents/guardians identify with any of the following categories?

   ☐Active U.S. Military ☐Veteran of U.S. Military ☐Refugee ☐Teen parent ☐Disabled

4. What is the highest level of education you have completed?

   ☐Grade 9 or less ☐Some high school ☐High school graduate ☐GED ☐Some college/vocational/associate degree ☐Bachelor/Advanced degree

5. What is your main form of transportation? ☐Bus ☐Car ☐Walking ☐Other (please specify_____)

6. Is your child/family involved with any of the following agencies or services?

   ☐DCF ☐Birth to Three ☐ECAT ☐Yale Child Study Center ☐Clifford Beers

7. Has your child ever been diagnosed with a disability?

   ☐ Yes, with a diagnosis of: _____ ☐No

8. Does your child require any supports for feeding (feeding tube, special techniques, etc.)?

   ☐ Yes, my child uses: _____ ☐No

9. Does your child use any mobility supports (wheelchair, walker, etc.)?

   ☐ Yes, my child uses: _____ ☐No

10. Is there anything else we should know about your child's needs? _____

11. What type of medical insurance does your child have?

☐HUSKY ☐Medicaid ☐Private health insurance (please specify _____)

12. Does your child have special dietary needs (if yes, please describe)? _____

13. Are there foods your child does not eat for religious or cultural reasons (if yes, please describe)? _____

14. Does your child still use a bottle? If yes, when? i.e. bed time, when fussy, etc. _____

15. Do you currently breastfeed your child? Yes / No

16. When was the date of your child's last doctor's appointment? _____

17. What was the date of your child's last dental appointment? _____

18. Does your child take any medication daily? (If yes, which ones?) _____

19. What are the medication's side effects, if any? _____

PLEASE READ THE FOLLOWING RESPONSIBILITIES AND SIGN BELOW:

I have read this form or have had it read to me in a language that I understand.

I certify that the information on this form is true and complete to the best of my knowledge. If I have knowingly given incorrect information, I may be subject to penalties for false statement as specified in the Connecticut General Statutes and to penalties for perjury under Federal Law.

I understand that I must provide the Care-4-Kids program and All Our Kin, Inc. with information necessary to determine eligibility and calculate benefits in a timely and accurate manner. I must permit the Care-4-Kids program to verify information independently.

_____ _____

Signature of Applicant **Date**

_____ _____

Signature of EHS Staff Member **Date**

CONSENT TO ACCESS INFORMATION

I, _____, the parent(s) or legal guardian(s) of _____ give permission for the staff of All Our Kin and my child's daycare provider to have access to all the information contained in my child's file, including health and dental information. I (We) also give permission for any inspectors from any regulatory agencies to have access to my child's file and health information.

I also give permission for the staff of All Our Kin and my child's daycare provider to obtain health information about my child from my child's physician / healthcare provider / dentist as is necessary to ensure the appropriate care of my child. I also give permission for the staff of All Our Kin and my child's daycare provider to obtain information about my child from other non-profit and social service agencies, including but not limited to the Connecticut Department of Social Services,

Yale Child Study Center, etc. I understand that all medical records, dental records, and other information obtained by All Our Kin and my child's daycare provider will be kept confidential.

I certify that this request has been made freely, voluntarily, and without coercion. I may revoke this authorization in writing at any time.

Parent/Guardian Signature: _____ **Date:** _____

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

ALL OUR KIN
414A Chapel Street, Ste.100
New Haven, CT 06511
Phone: 203-772-2294 Fax: 203-772-2386

I, _____, (name of parent/guardian) give permission for:

Name of child's doctor: _____
Doctor's office telephone number: _____
Address: _____ City: _____ State: _____ Zip : _____

Name of child's dentist: _____
Dentist's office telephone number: _____
Address: _____ City: _____ State: _____ Zip : _____

To release to the All Our Kin Early Head Start program information pertaining to my child's medical and dental screenings and/or treatment. This information will be used solely to plan and coordinate the care of my child and will be kept confidential.

Child's Name:_____ **Date of Birth:** _____
Last **First** **Middle**

Purpose: I understand that the specific purpose of this Authorization is in accordance with the regulations and guidelines of the Early Head Start Program.

Information to be disclosed: This authorization permits the above providers to disclose the following:

- ❑ All of my child's health information that the provider has in his/her possession, including information relating to any medical history, mental or physical condition, dental history, and any treatment received by my child.

Term: This Authorization will remain in effect until the child leaves the All Our Kin Early Head Start program.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

_____	_____	_____
Parent/Guardian Signature	Date	Signature of Witness