



# Lincoln Public Schools Early Childhood Program

For children age 3 or 4 on or before October 15, 2011

The Early Childhood Programs provided through Lincoln Public Schools offer a wide variety of services. The services are designed to support children and families across the community. **Parent participation is important in all program options.**

To apply, please bring your application along with the following 3 documents to the ExCITE Enrollment Office, located at Culler Middle School, 5201 Vine Street, Lincoln, NE 68504:

- 1. Certified copy of your child's birth certificate OR, if you do not have your child's birth certificate, other proof of child's identify and age (i.e., official birth records or passport) accompanied by an affidavit explaining the inability to produce a birth certificate.**
- 2. Child's immunization record**
- 3. Income verification for the past year. [We prefer a 2010 tax return, W-2s or a check stub or other verification of assistance received.]**

Please refer to the Definition of Income on the back of this sheet for a complete list of income sources to be included.

Thank you for completing the application. We look forward to working with your family. If you have questions, please contact the Lincoln Public Schools ExCITE Enrollment Office, 5201 Vine Street, (402) 436-1995.

English: Please call this number if you need translated services: 471-4515 or 436-1995

Arabic: —

Russian: Если вам требуются услуги переводчика пожалуйста позвоните по телефону: 471-4515 or 436-1942

Español: Por favor llame a este numero de teléfono si necesita servicios de intérpretes: 471-4515 o 436-1938

Vietnamese: Xin vui lòng gọi về số này nếu quý vị cần có dịch vụ thông dịch: 471-4515 hoặc 436-1939

Lincoln Public Schools is a Head Start Delegate Agency of  
Community Action Partnership Lancaster and Saunders Counties



### **Head Start Program Definition of Income**

Income means total cash receipts before taxes from all sources, with the exceptions noted below. Income includes Money wages or salary before deductions, net income from non-farm self-employment; net income from farm self-employment; regular payments from social Security or railroad retirement payments from unemployment compensation, strike benefits from union funds, workers' compensation, veterans benefits (with the exception noted below), public assistance (including Temporary Assistance for Needy Families, Supplemental Security Income, Emergency Assistance Money payments, and non-Federally funded General Assistance or General Relief Money payments); training stipends; alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the household; private pensions, government employee pensions (including military retirement pay), and regular insurance or annuity payments; college or university scholarships, grants, fellowships, and assistantships; and dividends, interest, net rental income, net royalties, and periodic receipts from estate or trusts; and net gambling or lottery winnings.

As defined here, income does not include capital gains; any assets drawn down as withdrawals from a bank, the sale of property, a house or a car; or tax refunds, gifts, loans, lump-sum inheritances, one-time insurance payments, or compensation for injury. Also excluded are noncash benefits, such as the employer-paid or union-paid portion of health insurance or other employee fringe benefits; food or housing received in lieu of wages; the value of food and fuel produced and consumed on farms; the imputed value of rent from owner-occupied non-farm or farm housing; and such Federal non-cash benefit programs as Medicare, medicaid, food stamps, school lunches, and housing assistance, and certain disability payments made to disabled children of Vietnam veterans as prescribed by the Secretary of Veterans Affairs.

The period of time to be considered for eligibility is the twelve months immediately preceding the month in which the application or reapplication for enrollment of a child in a Head Start program is made, or for the calendar year immediately preceding the calendar year in which the application or reapplication is made, whichever more accurately reflects the family's current needs.



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Referred by \_\_\_\_\_

|   |                    |   |                             |
|---|--------------------|---|-----------------------------|
| <b>Child's First Name:</b>  |                    | <b>Child's Last Name:</b>   |                             |
| <b>Date of birth:</b>   |                    | <b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female |                             |
| <b>Ethnicity/Race:</b> Is this child Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No  |                    |   |                             |
| <b>What is the child's race:</b> (Choose one or more)   |                    |   |                             |
| <input type="checkbox"/> American Indian or Alaska Native   |                    | <input type="checkbox"/> Asian  |                             |
| <input type="checkbox"/> Native Hawaiian or other Pacific Islander  |                    | <input type="checkbox"/> Black or African American                        |                             |
| <input type="checkbox"/> White  |                    |   |                             |
| <b>Do you speak English?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No   |                    | <b>Primary Home Language</b>  |                             |
| <b>Do you need a translator?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No   |                    |   |                             |
| <b>Does child receive Medicaid?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  |                    | <b>Medicaid #</b>   |                             |
| <b>Other Health Insurance?</b>  |                    | <b>Dental Insurance?</b>  |                             |
| <b>Parent/Guardian Name(s):</b>   |                    |   |                             |
| <b>Address</b>  |                    |   | <b>Zip Code</b>             |
| <b>Home Phone:</b>  | <b>Cell Phone:</b> | <b>Work Phone:</b>  | <b>Email:</b>               |
| <b>Child lives with:</b> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other If other, relationship to child _____                                  |                    |   |                             |
| <b>Number in family:</b>  |                    | <b>Number of children:</b>  | <b>Number in household:</b> |
| <b>Which program option(s) would you prefer?</b>  |                    |   |                             |
| <input type="checkbox"/> <b>Home Base</b> Children and families receive services through weekly home visits and participation in group socialization activities.  |                    |   |                             |
| <input type="checkbox"/> <b>Center Base</b> Children attend half-day center experiences in a classroom.   |                    |   |                             |
| <input type="checkbox"/> <b>Full Day/Full Year</b> <u>This Head Start program option is only offered by Community Action Partnership Lancaster and Saunders Counties.</u> See cover sheet for detailed information about this option. |                    |   |                             |
| <b>Is your child in child care?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  |                    |   |                             |
| If yes, what days and hours does your child attend? _____   |                    |   |                             |
| Child care center/provider name: _____  |                    |   |                             |
| <b>How will your child get to the program?</b> <input type="checkbox"/> Parent <input type="checkbox"/> School Bus <input type="checkbox"/> Other   |                    |   |                             |
| <b>If by bus, what is the pick-up address:</b>  |                    |   |                             |
| <b>What is the drop-off address:</b>  |                    |   |                             |

### Family Member Information

Please list all adults living in the household

| First & Last Name | Date of Birth | Sex | Last grade completed | Working part time or full time, student full time or part time, unemployed: | Relationship to child |
|-------------------|---------------|-----|----------------------|---|-----------------------|
|                   |               | M F |                      |   |                       |
|                   |               | M F |                      |   |                       |
|                   |               | M F |                      |   |                       |

Please list all children living in the household

| First & Last Name | Date of Birth | Sex | If attending school, what grade & where? | Relationship to child |
|-------------------|---------------|-----|--|-----------------------|
|                   |               | M F |  |                       |
|                   |               | M F |  |                       |
|                   |               | M F |  |                       |
|                   |               | M F |  |                       |
|                   |               | M F |  |                       |
|                   |               | M F |  |                       |

### Emergency Contacts

| Name | Address | Phone | Relationship to child |
|------|---------|-------|-----------------------|
|      |         |       |                       |
|      |         |       |                       |

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| The following information helps the program staff better understand the needs of your family. All information is <b>confidential</b> and is not shared outside of Lincoln Public Schools.  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| Do you have a concern about your child's development?<br>If yes, describe your concern:  | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your child currently receiving Early Childhood Special Education Services?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Was your child born more than three weeks early?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Did your child weigh less than 5 pounds at birth? If yes, birth weight _____ lb. _____ oz.   | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child had four or more ear infections during the past year?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your child have any of the following? (If so, please check)<br><input type="checkbox"/> Asthma <input type="checkbox"/> Heart Problems <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Other<br><input type="checkbox"/> Diabetes <input type="checkbox"/> Weight Problems <input type="checkbox"/> Cancer <input type="checkbox"/> Vision<br><input type="checkbox"/> Epilepsy or Seizures <input type="checkbox"/> Skin markings, ie: birth marks, scars, Mongolian spots | <input type="checkbox"/> | <input type="checkbox"/> |
| Is there any food your child cannot eat for medical or religious reasons?<br>What? _____ Reason _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your child on a special diet?<br>What kind? _____ Reason _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you or a family member identified a need or been involved in counseling in any of the following areas: (If so, please check)<br><input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Alcohol/Drug Issues <input type="checkbox"/> Child Abuse/Neglect<br><input type="checkbox"/> Domestic Violence <input type="checkbox"/> Parenting Needs <input type="checkbox"/> Anger Control<br><input type="checkbox"/> _____ Other _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your family had an open case with Child Protective Services in the past three years?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Is there an immediate family member currently incarcerated or involved with the legal system?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Does either parent need to complete their high school education?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Does either parent need to learn to speak English?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have an immediate family member with a life threatening disease or serious chronic illness? (ex. Cancer, diabetes, tuberculosis)  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have an immediate family member with a mental or emotional disability?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been divorced or separated from your spouse or significant other within the last year?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Has there been a death in the immediate family?<br>If yes, how was the person related to the child?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have dependable transportation for your daily needs?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you an immigrant or refugee in the last 5 years? If so, from where? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your family have enough food to meet your daily needs?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Is the parent/guardian currently deployed with the military?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Income verification document(s) submitted:<br><input type="checkbox"/> Income Tax Return <input type="checkbox"/> W-2 <input type="checkbox"/> Check stub <input type="checkbox"/> Other   |                          |                          |
| Do you receive any of the following type of assistance? If yes, verification is required.<br><input type="checkbox"/> TANF/ADC <input type="checkbox"/> SSI                      Caseworkers name: _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| I have included all income in the verification document(s) I have provided to the Lincoln Public Schools ExCITE/Head Start Program. (If you answer no, you must complete an Income Verification Worksheet which will be provided on request.)  | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you currently homeless or have you been homeless in the last year? Homeless is defined for our program purposes as living in a shelter, on the street, or temporarily staying in a residence not your own.   | <input type="checkbox"/> | <input type="checkbox"/> |
| If there is anything else you would like to tell us about your family, please write your comments here.  |                          |                          |

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 with the agency and will be accessible to me during business hours.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_